Getting Back In Through Others:
Patient Views on Psychotherapy for Complex PTSD

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I confirm that all names and identifying information have been changed to protect confidentiality.

SIGNED:
PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

Abstract

People who have been subjected to human mistreatment, such as torture or sexual abuse, may develop mental health problems for which they seek psychotherapy from the NHS. In the past, many were diagnosed as having Post-traumatic Stress Disorder, PTSD, and offered psychotherapy for this, although such treatment did not address all their symptoms. A new diagnosis has now been drawn up by the World Health Organisation (2012), which describes complex symptoms more comprehensively: Complex PTSD. It is set to be approved by WHO member countries in 2019.

There is little research on what patients with the new diagnosis might find helpful and this study set out to explore patient views on psychotherapy for Complex PTSD in a community setting in south London. While patients did not formally have the diagnosis, they had the symptoms of Complex PTSD at assessment. The study was innovative in that it took a collaborative, participatory approach where researchers, who had formerly been patients, were trained to carry out interviews (n=24) with each other, as well as contributing to the analysis.

The findings were that the key factor in recovery was enabling patients to rebuild relationships with others, beginning with the psychotherapist. Establishing trust in the relationship with the therapist, followed by other people, was identified as crucial, because trauma had been caused by human mistreatment. Although this may be considered a non-specific element of treatment, the participants considered it to be an active mechanism of change. They also emphasised that sufficient time, at least one year, had to be provided for therapy. These findings are explained by a psychoanalytic theoretical framework based on the concepts of attachment and object relations.

The findings come at an opportune time because the UK government through the National Institute of Health and Care Excellence (NICE), will need to recommend treatment guidelines for the new diagnosis based on the evidence of scientific studies, as well as clinician expertise and patient views.
Keywords: Complex PTSD, participatory research, qualitative research, Eye Movement Desensitisation and Reprocessing (EMDR), trauma-focused-Cognitive Behavioural Therapy (tf-CBT), Narrative Exposure Therapy (NET), refugees, sexual abuse
Patients’ voices

“It’s all about someone doing something to someone, and then maybe that’s the way out. It’s through getting back in through others, yeah, learning to rebuild again, isn’t it, yeah…” (Researcher 2, Transcript researcher analysis meeting Part 2, p.5, lines 17-20).

I was not trust anybody in the world, I tell the truth, and I think everybody who gonna be close to me was gonna kill me…If I didn’t tell her [the therapist], I couldn’t get more improvement…(Transcript interview with Q, p.3, lines 5-6).

The therapy has really helped, but I need more because I am just open, you know when you get that blast and you see that mushroom cloud, I am like the mushroom cloud, it hasn’t dissipated yet …this has opened up a lot of things and I won’t obviously go into depth, but my trauma happened when I was from the age of 5, and I’d say still ongoing, so to not haven’t spoken about that at all until the age I am now, I am in my fifties now (Transcript interview with D, p.2, lines 45-46 & p.3, lines1-3).
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1. Introduction

1.1 The Problem: Working with Torture and Abuse

This study arose from a clinical challenge in my work as a psychotherapist in an NHS Mental Health Trust in south London, where I am head of the trauma service in a secondary mental health psychological therapies team. My team and I assess about 75 patients annually, most of whom have experienced torture and/or sexual abuse, either as an adult or as a child, or both. Like other clinicians working with psychological trauma, we have been struggling for some time to find a therapeutic approach to help such patients.

Until now a diagnosis of Post-traumatic Stress Disorder, PTSD, has been given to people seeking help for mental distress following torture and/or abuse, although their symptoms are often more complex than those of someone who may have suffered a single trauma, such as a car crash. The original diagnosis of PTSD, formally devised in 1980, describes three main symptom clusters: re-experiencing the trauma in the present, avoidance of any reminders, and hypervigilance. The first-line psychotherapy treatments developed to address these symptoms consist of trauma-focused therapy where the patient re-lives the original trauma and comes to terms with it. A typical presentation might be, for instance, a patient who has been robbed at knifepoint after a late-night party and is experiencing nightmares and flashbacks of the attack, as well as avoiding going out after dark. Such a patient could be encouraged to go through the events with the therapist, re-evaluating the meaning it had for them, as well as current risk of danger.

Unfortunately, clinicians, such as those who contributed to the Expert Consensus Treatment Guidelines drawn up by the International Society for Traumatic Stress Studies, ISTSS, (Cloitre et al., 2012), have found that therapy takes longer for patients with more complex histories, and that dropout and non-response rates are high. The guidelines were based on a survey of fifty expert clinicians belonging to the ISTSS, an international professional membership organisation specialising in the field of traumatic stress. An example might be a refugee who had been imprisoned and tortured twice by the Syrian government, sought refuge in the UK and waited some time before being granted asylum. Or a British woman of Caribbean origin who was sexually abused by her father.
and used as a servant by her family. Some such patients do not engage at all and others continue to have symptoms after the end of therapy.

It is not hard to understand why this might be, given that many have undergone profoundly traumatic interpersonal experiences, such as childhood sexual abuse, or torture and sexual violence as an adult. The interpersonal nature of the trauma goes some way towards explaining the additional symptoms which typically include: emotional dysregulation, relationship problems based on difficulties trusting others, and feelings of guilt, shame and personal worthlessness.

Clinicians have been attempting for over 30 years to devise models of psychotherapy to help those with Complex PTSD symptoms, despite the absence of a formal diagnosis, and there is a range of literature on treatment outcomes for different patient populations, particularly refugees, veterans and those who have experienced childhood abuse. Our team has also adapted a range of treatment models, particularly groups, to address more effectively the difficulties which our patients experience (Matheson, 2016).

1.2 A New Diagnosis: Complex PTSD

Some of our difficulties, of course, are due to the extreme suffering of the patients themselves. At a clinical level, however, the absence of an accurate and comprehensive diagnosis has been an obstacle to devising effective treatment. This is because a psychiatric diagnosis may be influential, if not decisive, in the NHS in providing criteria for deciding what kind of help should be offered to those seeking psychotherapy. For example, in the Trust where I work all patients are given an ICD-10 diagnosis on the electronic records system. This usually provides the basis for what kind of treatment may be offered, with reference to the relevant guidelines from the National Institute for Health and Care Excellence, NICE.

In recognition of the complexity of mental distress caused by human mistreatment, a new diagnosis of Complex Post-traumatic Stress Disorder, CPTSD, has now been formulated and is scheduled for approval in 2019 by the World Health Organisation (WHO) for inclusion in the eleventh revision of its diagnostic manual, the International Classification of Diseases (ICD-11). The CPTSD diagnosis is summarised in Table 1.
Table 1: PTSD and Complex PTSD symptoms

<table>
<thead>
<tr>
<th></th>
<th>PTSD symptoms</th>
<th>Additional symptoms for C-PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>New ICD code: 6B40</strong></td>
<td><strong>New ICD code: 6B41</strong></td>
</tr>
<tr>
<td>Complex PTSD diagnosis</td>
<td>• Re-experiencing of the trauma</td>
<td>• Severe emotional dysregulation</td>
</tr>
<tr>
<td>includes:</td>
<td>• Avoidance of reminders of trauma</td>
<td>• Feeling a failure, worthless, ashamed &amp; guilty</td>
</tr>
<tr>
<td></td>
<td>• Increased arousal and hypervigilance due to persistent sense of threat</td>
<td>• Difficulties in sustaining relationships</td>
</tr>
</tbody>
</table>

I include the relevant description in ICD-11 here:

Complex PTSD is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterised by the core symptoms of core PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder.

In addition, Complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning (WHO, 2018).

It is important to mention here that there is an ongoing discussion among clinicians about whether some of those diagnosed with personality
disorder in fact may be more accurately diagnosed with Complex PTSD, given
the similarity in symptoms. This is significant because of the large numbers of
patients with personality disorder who seek psychotherapy from the NHS. In
the service where I work, a community secondary mental health team, this is
the psychiatric diagnosis attributed to the largest single number of patients. In
her seminal 1992 book, “Trauma and Recovery”, Herman said that among her
patients with Borderline Personality Disorder (BPD), she had documented
histories of severe childhood trauma “in the great majority (81%) of cases
(Herman, 1992, p. 126) and that BPD was best understood as a variant of
CPTSD.

More recently, the website of the mental health charity, MIND, discusses
the stigma experienced by those with a BPD diagnosis and asserts that
“…some people are given a diagnosis of BPD or another personality disorder
when complex PTSD fits their experiences more closely (http://www.mind.org).”
At the present time it is not known how many patients may be affected by this
issue of differential diagnosis (see APPENDIX 0. p.178).

It is also relevant to say here that the issue of cross-cultural applicability
was considered in the formulation of the new diagnosis of CPTSD (see
Appendix A. p.124), given that many of those to whom it may be applied are
displaced people and/or refugees. Some writers (Blackwell, 2009; Bracken et
al.1996) have criticised the application of diagnostic categories of Western
medicine as disrespectful of indigenous cultural understandings of mental
health, as well as for disregarding social and political factors. However, other
researchers and clinicians have described how they have attempted to integrate
Western models with varied cultural meanings and customs (Hinton & Good,
2016; Silove et al., 2014; Tay, Rees, Chen, Kareth, & Silove, 2015). This
position is arguably a compromise which clinicians can adopt with integrity. It is
the position which I take as a psychotherapist working in a multi-cultural setting.

1.3 Significance of the Problem

In this section I will describe briefly the social and economic context of the
study’s location in south London, and outline the demographic characteristics of
patients, and the numbers of people who may be involved. I will also describe
the modalities of psychotherapy which our team might offer for patients with
CPTSD symptoms as these modalities are already in place. The new diagnosis
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will eventually entail revised NICE guidelines for the treatment of CPTSD which makes this an opportune time for this study on patient views.

1.3.1 The setting
The significance of the problem may be introduced by a brief consideration of the location, which is the south London Borough of Lewisham. Lewisham has a population of 275,885 people and is one of the most ethnically diverse in the UK with 46.4% of the population from a black, Asian or minority ethnic background, according to the 2011 Census (Lewisham Borough Council website, 2018). It has high levels of poverty according to the Department for Communities and Local Government’s 2015 Index of Multiple Deprivation, IMD, cited in the Lewisham Poverty Commission Report (2017).

1.3.2 The team
I am registered as a psychodynamic psychotherapist and I work in the Integrated Psychological Therapies Team, IPTT, based in an outpatient unit at University Hospital Lewisham. The team is run by the South London and Maudsley NHS Mental Health Foundation Trust, SLaM. The team accepts an average of 378 referrals a year (2013-2017) from the borough primary care service, Improving Access to Psychological Therapies (IAPT), or from the Assessment and Liaison Teams, which assess and refer on patients with complex mental health needs, excluding those with psychosis. It can therefore be seen that patients referred to my team, as a secondary service, will have more complex, longstanding symptoms. In particular, patients with core PTSD are expected to be treated in primary care, while most patients with CPTSD symptoms in the borough of Lewisham are referred on to me, as lead for the trauma service. From 2013-2017, I received an average of 75 referrals a year.

1.3.3 The patients
The majority of people who are referred fall into two main groups: those who have been tortured and those who have been abused. Many of those who have been tortured, both men and women, have also been subjected to sexual violence as adults. They are mostly refugees or asylum seekers, with by far the largest number from Sri Lanka: 122 referrals in the last six years (2012-2018) which is 27% of all trauma referrals. This is because the borough of Lewisham
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has a large concentration of Sri Lankan residents, and refugees from Sri Lanka seek help from family and friends already here. Other countries of origin include Rwanda, Democratic Republic of Congo and Afghanistan.

The other main category of patients includes mostly women (although there are occasional referrals of men) who have been sexually abused in childhood in the UK, although some have immigrated from countries such as Nigeria and Jamaica. There is growing evidence that the scale of sexual abuse in the UK is more widespread than had previously been thought (Bentley et al., 2018), with catastrophic consequences for mental health. Some colleagues believe that the traumatic effects of abuse could be the major and largely hidden contributory factor to mental ill health (Allen, 2001).

There is a third group of patients, UK military veterans, whose symptoms may include those of CPTSD and are on occasion referred to the team for therapy, but their numbers are small: on average, two per annum. This may be due to the provision of specialist services outside the locality. It is useful to mention veterans here because I will discuss later some of the literature on CPTSD which has been written by clinicians working with veterans.

1.3.4 Adapted psychotherapy models

Like many clinicians working with such patients, in Lewisham we have provided a range of adapted psychotherapy models to address the symptoms which are now included in the ICD-11 diagnosis of CPTSD. These include women’s groups for those with a history of childhood sexual abuse; a refugee men’s group for Sri Lankan Tamil men which includes horticultural activities; and Narrative Exposure Therapy, (NET), which is an adaption of Cognitive Behavioural Therapy (CBT), initially devised for human rights cases. This is in addition to individual modalities: Eye Movement Desensitisation and Reprocessing (EMDR), trauma-focused Cognitive Behavioural Therapy (tf-CBT), systemic and psychodynamic psychotherapy.

We regularly collect data on outcomes, as is required in the NHS, and this is done in the form of self-report questionnaires. Although such data may give some indication of changes in symptoms, they do not provide detailed information on patient views of the psychotherapy they experienced. While patients were not given a formal diagnosis of CPTSD at the time of their treatment as the diagnosis did not exist, the symptoms noted in their
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assessments justify such a diagnosis in retrospect. Given that recommendations for treatment will eventually be drawn up by NICE, this is an opportune time to study patient views on psychotherapy for CPTSD.

1.4 Patient Views for NICE Guidelines

Following approval of the Complex PTSD diagnosis in 2019 at the WHO General Assembly, there will be some time for preparation of staff and systems, and implementation in each member country is planned from 2022 onwards. In the UK, NICE has recently revised its guidelines on PTSD (NICE, 2018) but as there are no scientific studies yet on treatment for CPTSD, the committee used a formal consensus method, the modified nominal group technique, to agree some overarching principles to facilitate engagement for those with CPTSD or other additional needs. The first of these was the importance of building in extra time to establish trust with patients (NICE, 2018). No detailed guidelines were given at this stage.

It is also notable that NICE has recently been criticised (Thornton, 2018) in its consultation on new guidelines for depression for relying too heavily on flawed methods in quantitative research at the expense of qualitative studies, and patient views. As this study takes a qualitative approach and focuses on patient views, it is intended to make a small contribution towards ensuring that future NICE guidelines on PTSD do not suffer from a similar deficit.

Although there are a number of outcome studies on psychotherapy models which have been adapted for Complex PTSD, patient views can only be inferred from these findings: if treatment is successful, patients might be expected to view it positively. Detailed information from patients on what is effective in psychotherapy for CPTSD, and why it is effective, is crucial at this time for clinical practice and service development. Such data could be the basis for decisions on whether or how psychotherapy may be changed in response to the new diagnosis as it is likely that any changes may be based on the adaptations which have already been attempted (McFetridge et al., 2017). Although participants in the study only had a diagnosis of PTSD at the time of psychotherapy, their symptoms at assessment would have been more accurately been described as CPTSD. A community setting is important because it gives better research-to-practice applicability. This study therefore
1.5 Background

1.5.1 Reflexivity: justification for researching my own service

In the interests of transparency, in this section I will explain my dual role as a researcher who was also a clinician in the service under study. To be specific, I was the psychotherapist or co-therapist for 17 of the 24 patients in the study and I managed and supervised the other psychotherapists whose patients were included. I undertook the study because I wanted to ensure the psychotherapy we offer is as helpful to patients as possible. I will provide below some biographical information to explain my motivation for undertaking the study and its participatory approach. I will also outline how I chose to undertake an adjunct participant observation in the psychoanalytic tradition of infant observation. One reason for this was to open up my subjectivity to objective scrutiny (Hinshelwood, 2012) as is attempted in infant observation. Key to this approach is the conceptualisation of the mind as having an unconscious component. The participant observation was also intended to provide triangulation for other methods.

1.5.2 A cross-disciplinary study: the tensions

I will then go on to outline the psychoanalytic theoretical framework which contribute to the methods and data analysis used in the study. I want to point out here that this study is cross-disciplinary in that it attempts to apply a psychoanalytic understanding of mental health based on the existence of an unconscious internal world to the study of psychotherapy provision in the NHS. Since the medical model of mental health, which is influential in the NHS, adheres to the primacy of demonstrable evidence of change, this has led to some tensions/contradictions in the study. For instance, the literature search of mainstream databases resulted in only two psychoanalytic papers by the same writer. One reason for this may be due to what Holmes (2018a) describes as the convention followed by psychoanalytic writers of producing case histories and theoretical papers which do not fulfil criteria for mainstream scientific journals. This therefore means that psychoanalytic psychotherapy is not recommended for PTSD by NICE guidelines in the UK or expert guidelines.
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As is observed in a recent editorial (Yakeley, 2018) in “Psychoanalytic Psychotherapy”, the journal for the profession in the NHS:

specific psychological treatments are increasingly likely to only be available if they can demonstrate sufficient empirical evident for their effectiveness to convince commissioners to pay for them, and therefore the range of therapies on offer is more limited (p.331).

As a psychoanalytic psychotherapist who has also trained as an EMDR practitioner, I wanted to explore how psychoanalytic theories could be applied to clinical practice in order to improve provision for people with CPTSD who may not respond well to current treatment for PTSD alone.

1.5.3 The role of psychotherapist as researcher

I undertook this study in order to find out what the patients in my service thought and felt about the psychotherapy they had received, and whether there were other factors they considered important in addressing CPTSD symptoms. As the service I run has dealt with 447 referrals in the last six years and many of them experienced CPTSD symptoms, this seemed to me a crucial question for future patients. This dual role of clinician and researcher begs the question: is it possible to do an academically rigorous study when the roles involve functions and feelings which may come into conflict? A positivist critique of this dilemma would point to the potential for systematic bias in demonstrating positive findings for my own work.

According to the Critical Appraisal Skills Programme (CASP) checklist for qualitative research, researchers are required to examine critically their own role, potential bias and influence in design, data collection and analysis (Critical Appraisal Skills Programme, 2018). The table below compares in brief some possible conflicts and coincidences in the roles of psychotherapist and researcher. The comparison shows the different tasks which had to be balanced in doing the research as I experienced them. The area I found especially difficult was the tension between ensuring the interviews were accomplished, and not harming former patients by pressurising them into attending and completing the interviews. While I hoped that it would be therapeutic for them to carry out the research activities, it was unknown if this would in fact be the result.
Table 2: Comparison of tasks of psychotherapist and researcher roles

<table>
<thead>
<tr>
<th>Psychotherapist</th>
<th>Researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find out what are therapeutic factors in patient recovery</td>
<td>Explore patient views on psychotherapy for CPTSD</td>
</tr>
<tr>
<td>Help patients recover</td>
<td>Promote participants’ empowerment including mental health</td>
</tr>
<tr>
<td>Ensure patients are not harmed</td>
<td>Implement academically rigorous study</td>
</tr>
<tr>
<td>Facilitate patients’ social interaction in peer support</td>
<td>Obtain interviews for transcription</td>
</tr>
<tr>
<td>Facilitate patients’ involvement in new activities in groups</td>
<td>Recruit participants for study</td>
</tr>
<tr>
<td>Act in patients’ best interests (this is first priority in Code of Ethics)</td>
<td>Complete thesis for professional doctorate</td>
</tr>
</tbody>
</table>

1.5.4 Power dynamics in therapy and research

A full consideration of my role may also include how the participants were influenced by my presence and behaviour. One likely dynamic was unequal power relations doubly reinforced by not only being a researcher with participants, but also a psychotherapist with former patients in a clinical setting.

Various measures were built into the design of the study to address the power imbalance. The most significant step was to take a participatory approach where patients implemented the data collection through interviewing each other, and collaborated in data analysis through selecting the themes for analysis. This led to some unexpected results as will be explained in Section 4.4.5 p.101. In addition, different colleagues with no personal investment in the study were consulted on two occasions to validate the themes.
1.6 Participant Observation

I included in the study an adjunct participant observation from my perspective as a clinician researcher by keeping a reflective log throughout the research process. As discussed above in Section 1.5.3 on p.17, I attempted to combine the role of clinician and researcher in this study. I was participating as the researcher who initiated and managed the research, as well as being responsible for analysis and writing it up as a thesis. However, I was also participating as a clinician, in particular a psychoanalytic psychotherapist, who uses psychoanalytic theory about the unconscious workings of the mind, to understand what is observed in oneself and other people. In addition to this, I had a role as former psychotherapist to some of the participants in the study, and I was known to the others as a psychotherapist. This was the role which motivated me to initiate the study because I wanted to know what they found helpful. It also influenced the participants’ attitude to me.

The observation was based on the model of an infant observation which is a necessary part of training as a psychoanalytic psychotherapist. It involves the observers in explicitly analysing the experiences they observe in themselves and others, using psychoanalytic theory to do so (Bick, 1964). Bick conceptualises the role thus:

- the observer should feel himself sufficiently inside the family to experience the emotional impact, but not committed to act out any roles thrust upon him, such as giving advice or registering approval or disapproval. This would not seem to exclude him being helpful as a particular situation arose—by holding the baby, or bringing it an occasional gift. In other words, he would be a privileged and therefore grateful participant observer (1964, p.558).

The role differs from a participant observation in the social sciences in the use of psychoanalytic theory about the unconscious, including object relations and attachment theory (outlined in Section 1.8.3, p.23)

My participant observation study had a dual purpose. Firstly, I aimed to make my role as clinician and psychotherapist transparent to scrutiny by explicitly analysing it. Hollway and Jefferson (2000), who pioneered a psychoanalytic approach to research, say that subjective involvement can be
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both a danger and a positive resource, depending on how the researcher can use this knowledge. My intention was to use the analysis of my role to enhance understanding of the dynamics of the research process and therefore also contribute to answering the research question. By framing it as a participant observation, I am owning the application of psychoanalytic theory as my choice, rather than that of the participants.

Secondly, I also intended that a participant observation based on a psychoanalytic approach would provide triangulation for the thematic analysis approach used for the analysis of the interviews and group meetings. I felt that psychoanalytic theory could provide a more sophisticated conceptual model to understand what may be helpful, and why, to people with CPTSD symptoms (see 3.1.4, p.56).

1.7 Biographical Information on Researcher

In the interests of transparency I will now provide biographical information about my background and motivation to introduce the study’s participatory approach, as well as to explain the influence of researchers in other fields on the study.

1.7.1 Influence of liberation psychology

I would like to mention first the influence of literature from other fields in choosing a participatory methodology. In the mid-1980s I worked as a news correspondent for the BBC in El Salvador during the civil war. As journalists we often consulted academics at the Jesuit-run university and one of these was a psychologist, Ignacio Martín-Baró, also a Jesuit priest, whose papers have been translated into English in a book entitled “Writings for a Liberation Psychology”(1994). He argued that psychology is obsessed with methods and measurements and blind to many of the structural determinants of individual and group life. He thought that the aims of liberation psychology should be to tackle social exclusion, work with the victims of state oppression and implement social analysis. His methodology included public opinion polls about issues of the day such as peace talks between guerrillas and government.
1.7.2 Influence of community organization

I had experience of implementing participatory methodology because I went on to work in overseas community development at British aid agencies, including War on Want. Writers in the development discipline include such activists as Paolo Freire (2000), the Brazilian educator, and more recently John Gaventa (2001) who pioneered action research in the US. My thinking on methodology was informed by such theories, and I wanted to investigate if their application in the London borough of Lewisham would have benefits for service users here.

1.7.3 The UK service user movement

More recent work includes literature by those who have used mental health services themselves and are strong advocates for service user involvement in research, such as Diana Rose (Rose, 2003; Rose, Thornicroft, & Slade, 2006) at South London and Maudsley NHS Trust, and Neil Springham (2011) at Oxleas NHS Foundation Trust. Springham set up a research network as part of a programme for recovery. As a psychotherapist, I was interested in the possibility of using the research process to promote recovery by involving patients as fellow researchers. As a clinician I wanted to address the symptoms of my patients with CPTSD through the research. Their feelings of worthlessness and powerlessness, as well as their problems with relationships, were relevant to the choice of a qualitative, participatory methodology.

1.8. Theoretical Frameworks for Psychological Trauma

1.8.1 Cross-disciplinary research and practice

I want now to highlight how the tensions involved in being a psychoanalytic researcher reflect similar tensions in being a psychoanalytic practitioner in a medical setting. I have mentioned that psychoanalytic writers typically produce case histories and theoretical papers which “do not meet conventional academic and scientific criteria for evidence, lack generalisability and tend only to be of interest to a fairly restricted group of like-minded practitioners (J. Holmes, 2018a, p. 120).” This has meant that the provision of psychoanalytic psychotherapy has been side-lined in many public sector services. However, in the treatment of PTSD which is the focus of this study, evidence-based psychotherapy such as CBT has often not been found to be
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effective for those with more complex histories whose trauma has been inflicted by other people (see for example, Dorrepaal et al., 2014; Lonergan, 2014). I argue here that psychoanalytic thinking based on attachment theory may help to understand why this is and how the factors suggested by participants in this study may provide guidelines for future psychotherapy provision. I will now detail relevant theories on attachment using a psychoanalytic framework, as well as summarising briefly other theories that underlie the current evidence base for trauma-focused therapy. These include theories from physiology and neuroscience.

1.8.2 Physiological theory: an anxiety-based response

It is useful to start with a physiological understanding of core PTSD since its symptoms are included in those of CPTSD in ICD-11. The theoretical model which underpins current recommended psychotherapy modalities for core PTSD is based on the understanding that traumatic events have physiological effects (Lanius, Vermetten, & Pain, 2010). The anxiety provoked by life-threatening or terrifying experiences activate the amygdala, which enables rapid involuntary responses to boost survival. This then bypasses the hippocampus which in normal circumstances processes memories cognitively into a coherent narrative. The result is that the trauma becomes “fixed in the mind” as van der Kolk puts it (2000, p. 245), with the traumatic events stored in a fragmentary way and still connected up to survival-based physical responses such as hypervigilance. This was memorably described by van der Kolk as “The body keeps the score” (2014).

Current treatments recommended for PTSD by NICE (NCCMH, 2005), which are Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), involve unblocking the trauma through exposure or processing the trauma while orienting to present safety. This is the theoretical basis for trauma-focused CBT. While EMDR (Shapiro, 2001) may not involve talking directly about the trauma if the patient is unable to do so, it does involve visualising the worst of the traumatic events while experiencing bilateral stimulation. Side-to-side eye movements resembling Rapid Eye Movement (REM) sleep have most evidence for success. Audio and tactile stimulation using headphones, buzzers or tapping may also be helpful.
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Neuroscience also demonstrates a less common neurobiological response to trauma, a disruption in consciousness or dissociation (Lanius et al., 2010), which may include numbness, freezing and depersonalisation. This involves over-modulation of affect, rather than under-modulation, and some authors (Schmahl et al., 2010) suggest they are sequential stages which can also be seen in animal defensive behaviour, such as a mouse playing dead to deceive a cat. Patients experiencing these symptoms may not be helped by exposure-based therapies.

1.8.3. Attachment and object relations

The ICD-11 proposal (see Appendix A. p.124) for the new diagnosis emphasised that: “The stressors associated with Complex PTSD are typically of an interpersonal nature, that is, are the result of human mistreatment rather than acts of nature...or accidents...(WHO, 2012, p. 2)”. A more sophisticated theoretical model than the physiological explanation is therefore needed to understand Complex PTSD and a psychoanalytic perspective is useful here, drawing on ideas from attachment theory, as well as object relations. While psychoanalysis may be perceived as focussing on the internal world of the human mind, particularly the unconscious, it does also pay great attention to the interaction between internal and external worlds, particularly the formative influence of relationships with real people on the mind. The significance of others for mental health remains throughout the life cycle, as is explained by attachment theory.

Much psychoanalytic theory has conceptualised PTSD primarily as an inability to cope with loss (for instance, Levy & Lemma, 2004), following Freud’s theory in “Mourning and Melancholia” (Freud, 1917). However, it is more useful for the research question to highlight the contribution of attachment theory with some mention of its basis in object relations theory. I will now go on to explain the theoretical contributions of psychoanalytic clinicians including Klein, Bowlby, Bion and others, which may be relevant to an understanding of CPTSD and its treatment. I will also mention the concept of mentalisation developed by Bateman and Fonagy, as well as the importance of recent developments in neuroscience that may support a psychoanalytic theoretical framework by providing visible evidence of changes to the brain and its activities in response to human interaction.
1.8.4 Klein and object relations

Klein (1952a/1975) theorized that an infant’s early experiences of being cared for, and specifically its experiences of being fed, are likely to define its future relationships with other people. Klein began by postulating that a newborn baby experiences anxiety of a persecutory nature, which means it feels every discomfort as inflicted on it by hostile forces. Because the mother represents a baby’s whole world, this means that both good and bad come from her. Klein particularly focused on envy of the mother’s feeding capacity as having a negative impact on the infant’s psyche, leading to unconscious fears of its own and others’ destructiveness.

Klein also postulated that the real world and people in it, become part of the infant’s mental life through introjection, or being taken into the self. In its internal world, the infant splits its objects into good and bad to avoid the unmanageable anxiety of good being destroyed by bad. As the infant develops, Klein believed, it comes to realize that the mother who feeds it and the mother who does not, are one and the same person, leading to pain and guilt which she described as the depressive position. She also explained that the mother, the external object, has to be there to help the infant test reality, which is her capacity to survive the destructive impulses of her baby without retaliating.

Klein emphasised that the infant’s “repeated experiences of external reality become the most important way of overcoming his persecutory and depressive anxieties (Klein, 1952b/1975, p. 112).” This emphasis on the importance of early relationships for later mental health was elaborated by Bion and then Bowlby, as well as others not discussed here, such as Winnicott.

1.8.5 Bion and emotional containment.

Bion built on the ideas of Melanie Klein about the significance of early carers in providing vital emotional help for the infant in developing the capacity of its mind to process feelings. In his book “Learning from Experience (1962a)”, Bion described the capacity of the mother to absorb and process the baby’s overwhelming feelings (beta elements) as containment and saw it as vital for developing the capacity to think. He described the mother’s state of mind as “reverie”, a state with some similarities to day-dreaming where she enables the infant to make sense of and tolerate states of anxiety. He theorised that the
infant comes to understand that the mother is a separate person, rather than concretely inside the self, which allows for an internal representation of her, as well as further symbolic functioning. The infant realises that its feelings do not have an effect in concrete reality unless it acts upon them. This then enables sufficient intrapsychic space to think about feelings, which facilitates mature emotional development, including intellectual ability.

1.8.6 Mentalisation

Fonagy and Bateman (2006) agree that healthy attachment is necessary for the symbolic function, which is key to an understanding of our own and other people’s minds. In developing a psychotherapeutic approach for borderline personality disorder (BPD), they describe this capacity to comprehend and use the knowledge of mental processes as mentalisation. They highlight that BPD is characterized by difficulties with emotional regulation, impulse control, and instability in relationships and in self-image, and look to the framework of attachment theory to explain these difficulties. It is useful to note here that these symptoms are shared with those of the new CPTSD diagnosis.

They suggest that BPD patients have been constitutionally vulnerable and/or subject to neglect or even abuse in early relationships and that this has resulted in their “decoupling their capacity to deal with their own or others’ mental states comprehensively, particularly in an attachment capacity” (Fonagy & Bateman, 2006, p. 415).

Bateman and Fonagy devised a therapeutic intervention in which patients learned how to mentalise in the context of attachment relationships, that is, group and individual psychotherapy. They say:

*The therapist’s mentalising in a way that fosters the patient’s mentalising is seen as a critical facet of the therapeutic relationship and the essence of the mechanism of change. The crux of the value of psychotherapy is the experience of another human being having the patient’s mind in mind* (Fonagy & Bateman, 2006, p. 415).

1.8.7 Bowlby and attachment

This understanding of the formative importance of external carers on the developing mind was established by Bowlby, who highlighted the importance of real experience as opposed to that of the internal world in infantile relationships.
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However, Bowlby also elaborated an intra-psychic explanation of how the human mind develops in the context of relationships with others, particularly carers. He theorised that children form Internal Working Models of relationships based on those with carers and that poor early relationships may lead to later emotional vulnerability (Bowlby, 1969). He said: “In terms of attachment theory [a child] is described as having built up a representational model of himself as being both able to help himself and as worthy of being helped should difficulties arise (1979, p. 136).” He described how children seek help from attachment figures when tired, hungry, ill or alarmed, that is help is sought when physical or psychological threats are experienced.

Bowlby developed his theory through his work with children who had experiences that might be seen as traumatic, particularly separation from or loss of early carers. Symptoms resulting from trauma can be then be understood through an attachment lens by viewing psychological disturbance as the breakdown of Internal Working Models, not only of others, but also of oneself. Bowlby held that attachment behaviour continued throughout the human life cycle “from the cradle to the grave.” He was greatly influenced in his thinking by Fairbairn (1963) who held that the driving force in the human mind is a fundamental need to relate to and connect with other people.

Later psychoanalytic writers specifically apply attachment theory to adults who have experienced trauma and this is why it is relevant for this study on CPTSD. For example, Lemma sees trauma as “an attack on attachment” (Lemma, 2004, p. 5) because trauma may constitute an experience of a breach in the quality and security of attachment relations. Herman (1992) encapsulates this powerfully when she talks about how “traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others” (Herman, 1992, p. 51). Other clinicians such as De Zulueta (2006) suggest that the disorganised style of attachment, often seen in such patients, could more accurately be seen as traumatic attachment, as this encompasses both the origins and current experiences of attachment problems.

Lemma emphasises the importance of both internal object relationships, and the quality and presence or absence of external relationships at the time of the trauma. She also discusses the importance of emotional resilience, which
may come from a secure internal scenario capable of holding “the self like a ballast” (Lemma, 2004, p. 9).

**1.8.8 Neuroscience**

Klein and Bowlby devised their theories through observing the behaviour of infants and young children. More recent developments in neuroscience have provided demonstrable evidence of the significance of attachment through studying the activity of the brain itself through advances such as the functional magnetic resonance imaging scan (MRI) and positron emission tomography (PET). In particular, Schore brings together evidence that shows that “the self-organisation of the developing brain occurs within the context of a relationship “with another self, another brain” (Schore, 2003, p. xv). Good parental nurturing results in more activity in parts of the brain capable of thinking cognitively; this supports the theories of Klein and Bion on symbolic functioning and what Fonagy and others term mentalisation.

Correspondingly, early developmental deficits in nurturing may cause changes to the brain, that can disable people in these areas of mental life (Gerhardt, 2004). This may make them vulnerable to symptoms such as those seen in CPTSD later in life. Veterans and refugees diagnosed with Complex PTSD may not have early developmental deficits but have had damaging interpersonal experiences that may change disastrously their view of themselves, other people and the wider world. They often suffer the shame, guilt and sense of worthlessness also seen in those who have suffered developmental trauma.

**1.9 Implications of the Study for Clinical Practice**

I have described above how attachment theory conceptualises the significance of the interaction between internal and external worlds for the development of the human mind. I have also described how this conceptualisation may be particularly useful to understand the symptoms of those who have experiences of human mistreatment. It may also be significant for their recovery, as Seager (2006) explains. His paper on what psychological safety means in the context of mental health services in the UK is relevant to this study because for patients who have experienced extreme trauma the provision of safety is crucial. Many of those seeking treatment find other people
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both psychologically and physically threatening, as is suggested by the quotation from a participant in the study on p.4 of this thesis: “I was not trust anybody in the world, I tell the truth, and I think everybody who gonna be close to me was gonna kill me...”. Seager emphasizes how secure attachment and social networks are vital for recovery and this will be affirmed in the Analysis 4.2 p.80. Seager says that psychological safety means:

1. To be held in mind and thought about in an empathic way by at least one other person in whom there is at least a basic level of trust (i.e. attachment) and with whom there is reasonably regular contact and the opportunity of rapid support at times of heightened need.

2. To feel connected to other human beings socially in a way that affords a sense of belonging, identity, shared meaning and purpose. (Seager, 2006, p. 271)

Seager also goes on to explain that:

A hospital is much more than a place where an illness gets treated. It is a place where new attachments are sought out and also resisted, where the hope of being listened to, understood, contained and ‘reached’ is re-stimulated and defended against (Seager, 2006, p. 270).

His description of the importance of attachment in a hospital setting was seen in the implementation of this research (see Section 4.4 p.98)

1.10 Implications of the Study for Research

In his recent book, “Researching the Unconscious”, Michael Rustin asserts: “Psychoanalysis has been unable to learn sufficiently from research in the psychological, biological and social sciences, and these human sciences have found it difficult to take account of the reality and significance of unconscious phenomena” (2019, p. 2). He describes attachment theory as a “bridge” between mainstream human sciences and psychoanalysis because “while absorbing some of the central insights of the psychoanalytic theory of infant development, [attachment theory] nevertheless developed laboratory-based procedures to test and validate its hypotheses (2019, p.2). This study attempts to straddle that bridge by applying psychoanalytic ideas on attachment and object relations to the analysis of data on patient views.
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Progress in clinical practice in the field of Complex PTSD has been limited, partly because NICE guidelines have been confined to the evidence base for the diagnosis of core PTSD. However, a range of outcome studies has been done with different population groups, resulting in professional guidelines for CPTSD treatment in the US (Cloitre et al., 2012) and the UK (McFetridge et al., 2017), which lay out a phased approach, as illustrated in Table 3 below.

Table 3: A phase-based approach to Complex PTSD

| Phase 1     | Establishing safety and trust |
|            | Stabilizing symptoms          |
| Phase 2    | Trauma-focussed therapy       |
| Phase 3    | Re-integration into community, family life and relationships |

Recently there have been calls by senior clinicians for a re-definition of the research approach. In a special issue of the European Journal of Psychotraumatology called “Trauma and PTSD: setting the research agenda”, Cloitre (2015) asserted that PTSD treatment, development and implementation had “occurred without the substantial involvement of patients and trauma survivors, who have particular insight about their primary concerns and treatment preferences ” (2015, p. 1). She concluded that there was a need for research to evaluate the role of patient preference in enhancing treatment engagement, adherence and outcome.

This call was affirmed by a psychiatrist working with US veterans, Maria Steenkamp (2016), who called for a more holistic research approach by incorporating the views and expertise of both clinicians and patients to reflect more accurately real-world practice. These opinion papers have been included in the literature review below (see p.50).

This study, which takes a qualitative, participatory approach to exploring the views of patients in the community, is a response to the need for research on patient views.
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1.11 Summary of Research Aims

• To explore the views of patients in the community on psychotherapy for CPTSD

• To apply psychoanalytic concepts and thinking to an understanding of CPTSD and relevant factors for effective psychotherapy

• To take a participatory approach where patient researchers collaborate with the clinician researcher in data collection and data analysis (this took the form of interviewing each other about their views and identifying themes for the analysis)

• To promote recovery for patients through research participation

• To contribute to the discussion on NICE guidelines for the treatment of the new diagnosis of CPTSD

1.12 Research Question

• What are the views of patients in the community on psychotherapy for the new diagnosis of CPTSD?
2. Literature Review

2.1 Rationale for Literature Review

I have said that there are tensions in a cross-disciplinary study such as this because I am attempting to apply psychoanalytic thinking to psychotherapy as it is practised in the medical setting of the NHS. The medical model takes a positivist approach in which results are measured, generally quantitatively, whereas psychoanalytic writers seldom meet mainstream academic and scientific criteria for evidence (Rustin, 2019). This tension was evident in the literature review, where initial scoping searches of the mainstream medical and psychological databases resulted in little relevant psychoanalytic literature. The psychoanalytic community has its own database, Psychoanalytic Electronic Publishing (PePWeb) but there were no relevant results from a literature search on the research question, apart from a paper by the author (Matheson, 2016).

The work of psychoanalytic writers has been mentioned in the preceding chapter, and in this chapter I have taken a broader approach to the literature by implementing a systematic review through mainstream databases and academic journals. However, it must be noted that the most complex cases, including torture and childhood sexual abuse, are often the work of psychoanalytic clinicians, and I argue that psychoanalytic thinking on attachment has particular relevance to psychotherapy for CPTSD.

Aside from the tensions between psychoanalysis and evidence-based practice, there was an additional challenge in reviewing the literature because the diagnosis of Complex PTSD has not yet been formally recognised through inclusion in ICD-11. However, there is a wide range of research literature on the efficacy and effectiveness of adapting psychotherapy for CPTSD symptoms from core PTSD treatment and therefore I decided to review this literature as being most relevant.

I found that there is little research on patient views of treatment for core PTSD, although it might be inferred that positive outcomes may include satisfied patients. Therefore because of the paucity of research on patient views, I decided to include relevant outcome studies and systematic reviews of adapted psychotherapy for CPTSD symptoms in order to gain an understanding of what kind of psychotherapy might be helpful for patients with Complex PTSD.

As CPTSD is an evolving field where new research into different treatment models for diverse population groups will be necessary before an
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evidence base is established, I also reviewed the international professional guidelines for the treatment of CPTSD, and other clinician opinion papers on adapted treatment. I felt this was useful because clinical judgement and expertise are an important aspect of evidence-based practice (Sackett et al, 1996).

Summary of aims of literature review

The literature review had three aims:

1. To explore the literature on patient views of psychotherapy for PTSD where patients had been identified as having the additional symptoms of CPTSD.
2. To explore outcome studies on psychotherapy for PTSD adapted for CPTSD symptoms, on the understanding that if patients recovered they may have had a favourable view of psychotherapy or to ascertain what their views were instead.
3. To explore clinician expertise and opinion on psychotherapy for CPTSD symptoms.

2.2 Search Strategy

At the beginning of the study on 12/2/2017, a first literature search for scoping purposes was done on three databases: PubMed, CINAHL and PsycARTICLES for relevant research. The search terms were “complex PTSD” in the abstract from 2010-2017. A PRISMA flowchart with details of the search strategy is included below, Figure 1.

1. Relevant research was defined as:
   i. Patient views on psychotherapy
   ii. Participants with Complex PTSD or histories of complex trauma
   iii. Focus on psychotherapy treatment
   iv. Adult participants
   v. Professional guidelines for Complex PTSD based on empirical studies
   vi. Systematic reviews of empirical studies
   vii. Empirical studies of treatment models adapted for Complex PTSD

2. Exclusion criteria:
   i. Empirical studies already covered in systematic reviews
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ii. Focus on children/adolescents
iii. Co-morbidity
iv. Focus on biological factors
v. Single case studies
vi. Focus on diagnosis/assessment

3. A total of 65 results were found. 45 were excluded because they did not meet the inclusion criteria above. Full text was obtained for 20 results. After reading them, a further review using the exclusion criteria in 2. above gave five results. One of these was a paper on the PsycINFO database by Schottenbauer and colleagues (2008a), which took a psychoanalytic perspective. I found on reading it that it was one of two linked papers published in separate issues of the same journal.

4. A second search with a more rigorous focus to include patient views on treatment was done on 11/8/2018 of three databases: Medline, PsychINFO and EMBASE. See Appendix B for search strategy. The revised search terms were:

("complex PTSD" OR "complex Post-traumatic Stress Disorder" OR "complex posttraumatic stress disorder" OR “COMPLEX PTSD”).ti,ab combined with:

((view* OR opinion* OR experience* OR feedback* OR preference*) ADJ4 (patient* OR client* OR "service user*")) .ti,ab combined with:

(psychotherapy OR treatment).ti,ab

5. There were 23 results. Five duplicates and one result already included in the first search were removed. The inclusion criteria in 1. above were applied. Fourteen did not meet the inclusion criteria. There were no results which focused on patients’ views, apart from single case studies. Three full texts were read and excluded because they were not relevant according to the exclusion criteria in 2. above.

6. There are two specialist international journals in the field of traumatic stress studies, the Journal of Traumatic Stress, and the European Journal of Psychotraumatology. They were hand searched from 2000-2018 for results fitting the criteria for relevant research above. This gave five results.
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7. Throughout the period of the research an ongoing citation search of books and academic papers was done including the PTSD Research Quarterly published by the US Department of Veteran Affairs. In 2018, Volume 29 was devoted to Shared Decision-making for PTSD with a review of featured articles. The citation search provided six more relevant results making the total number of relevant studies identified 16.

8. The CASP checklist for systematic reviews was applied to the literature reviews, the CASP checklist for qualitative research was applied to the qualitative studies, the AGREE Checklist was applied to the guidelines. To evaluate the discussion papers and opinion piece, I adapted the CASP checklist questions, as below:
   A. Are the opinions/arguments valid?
   B. What are the opinions/arguments?
   C. Will the opinions/arguments help locally?

   A.
   1. Is paper focussed in terms of population, interventions, comparisons, outcomes?
   2. Do the writers have relevant clinical and/or expertise which might enable them to talk with credibility?
   3. What bias might the writer have?

   B.
   4. Clarity of the arguments themselves?
   5. Are the arguments put in context to help the reader understand their importance?

   C.
   6. Are the arguments relevant to clinical practice locally?

9. I allocated one of three categories to questions in each checklist: weak, moderate or strong to evaluate each paper. A summary of the main findings of the literature review is divided into three sections on patient views (Table 4), outcome studies (Table 5) and clinician expertise (Table 6).
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Figure 1: Flowchart showing stages of literature search outcome, adapted from PRISMA (Moher et al., 2009)

Records identified through 2 database searches (n = 88)
Records identified through hand search of specialist websites including 2 journals (n = 5)
Records identified through ongoing citation search (n = 6)

Records screened after duplicates removed (n = 99)

Records excluded (n = 61)
Reasons: focus on children
Focus on co-morbidity
Focus on biological
Single case studies
Focus on diagnosis
Empirical studies

Full-text articles & books assessed for eligibility (n = 38)

Full-text articles excluded (n = 20)

Studies included in systematic review (n = 18)
## PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

### Table 4: Summary of findings from the literature review: patient views

<table>
<thead>
<tr>
<th>First Author Date Country Study type</th>
<th>Title</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusions</th>
<th>Critical appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelo et al 2008 US Qualitative study</td>
<td>“I need to talk about it: a qualitative analysis of trauma-exposed women's reasons for treatment choice”</td>
<td>Community sample of 71 women viewed a video presentation on treatment and then completed questions by computer on their preferences which were coded for analysis</td>
<td>81% of women had preference for Prolonged Exposure therapy over medication or no treatment with beliefs such as “Confronting trauma is important for healing.”</td>
<td>Women preferred Prolonged Exposure because they felt talking about trauma was necessary for recovery</td>
<td>CASP Qualitative Checklist: Weak/Moderate. Only half of sample had PTSD diagnosis. Sample was not treatment-seeking. But adds to knowledge in asking for reasons for treatment preference.</td>
</tr>
<tr>
<td>Gilman et al. 2012 US Cohort study</td>
<td>Hope as a change mechanism in the treatment of posttraumatic stress disorder</td>
<td>Patient-rated measures of hope using the Hope Scale (Snyder et al., 1991) with 164 US veterans before, during and after Cognitive Processing Therapy</td>
<td>164 participants, both men &amp; women, mean age 50 years, Half Vietnam vets, showed positive correlation in increase in hope with decrease in PTSD symptoms, affirming importance of helping patients reframe cognitions of traumatic events more positively</td>
<td>Hope is a nonspecific change mechanism toward symptom reduction in PTSD among US veterans whichever modality is used.</td>
<td>CASP Cohort Study Checklist: Moderate. No formal diagnosis of CPTSD. Absence of a control group. Missing data 4.7%. Effect sizes large. No long-term follow-up after treatment. Assessment interviews not done by veterans’ individual therapist. Some limitations in</td>
</tr>
<tr>
<td>Simiola et al. 2015</td>
<td>Preferences for trauma treatment: a systematic review of the empirical literature</td>
<td>Six databases searched for studies on treatment preference in trauma survivors, resulting in 38 studies, 32 quantitative &amp; 6 qualitative</td>
<td>6,091 individuals represented, 62% female. One-third of studies used military samples, 11 studies used non-clinical samples</td>
<td>Strong preference for psychotherapy over medication. Strong preference for talking about trauma. It is important to ask patients what they want as preferences may influence outcome.</td>
<td>CASP Systematic Review Checklist: Moderate. Mainly considered core PTSD rather than CPTSD. Samples were not random. Studies did not have same inclusion/exclusion criteria or measures. But large numbers.</td>
</tr>
<tr>
<td>US Systematic review</td>
<td></td>
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### Table 5: Summary of findings from literature review: outcome studies

<table>
<thead>
<tr>
<th>First Author</th>
<th>Date</th>
<th>Country</th>
<th>Study type</th>
<th>Title</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusions</th>
<th>Critical appraisal</th>
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<tbody>
<tr>
<td>Classen et al.</td>
<td>2017</td>
<td>Canada</td>
<td>Cohort study</td>
<td>A naturalistic study of a brief treatment program for survivors of complex trauma</td>
<td>54 women took part in intensive 8-week multi-modal therapy programme, with weekly resource groups beforehand. Assessments done with 8 measures &amp; analysed using one-way repeat ANOVAs over 4 time-points</td>
<td>At 6-month follow-up, 60% had fewer PTSD symptoms and 30% had changed attachment style from unresolved to other styles.</td>
<td>Brief intensive multi-modal staged approach can be effective in treating women with histories of chronic trauma including improvements to attachment style</td>
<td>CASP Cohort Study Checklist: Moderate. Small number &amp; no control group. No indication which module of treatment successful. Sample carefully selected to include those not in crisis and with prior therapy experience. But adds to knowledge in considering changes to attachment.</td>
</tr>
<tr>
<td>Cloitre et al.</td>
<td>2010</td>
<td>US</td>
<td>Cohort study</td>
<td>Treatment for PTSD related to childhood abuse: a randomized control trial</td>
<td>104 women with histories of abuse took part in comparison of 2-phase treatment of stabilisation (STAIR) &amp; exposure therapy compared to 2 controls. Symptoms were measures &amp; analysed using logistic regression &amp; likelihood ratio tests</td>
<td>STAIR &amp; exposure phased treatment more likely to sustain symptom improvement than exposure treatment alone. More improvement in interpersonal problems and dropout rate also lower for the STAIR/exposure.</td>
<td>Phase-based treatment which includes STAIR and exposure had greater benefits than other treatments</td>
<td>CASP RCT Checklist: Moderate/strong. Small numbers: 104. Control treatments were not stand-alone but combined with others. No study of exposure alone. High dropout rates in all groups.</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Methodology</td>
<td>Findings</td>
<td>Recommendations</td>
<td>AGREE Checklist</td>
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<tr>
<td>Cloitre et al 2012 US</td>
<td>ISTSS Expert Consensus Guidelines for Complex PTSD</td>
<td>Survey of 50 expert clinicians, evidence of 9 published studies of clinical trials with evidence for stabilisation phase in CPTSD</td>
<td>84% of 50 expert clinicians endorsed a 3-phase approach for CPTSD: 1. Stabilisation 2. Trauma processing Rebuilding relationships</td>
<td>Recommended model is 3-phase treatment for CPTSD guided by assessment of needs</td>
<td>AGREE Checklist: Moderate. Guidelines signed by 13 experienced clinicians, mostly in US. Clarity on phased approach. They were reviewing their own work so ‘researcher allegiance’. No results from work with refugees. No patient consultation. No declaration of interests.</td>
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<tr>
<td>De Jongh et al. 2016 Netherlands</td>
<td>Critical analysis of the current treatment guidelines for Complex PTSD in adults</td>
<td>Critique of 9 studies in Guidelines and discussion of 24 other studies with evidence in favour of trauma therapy only</td>
<td>Outcomes for trauma therapy alone can have good results for patients with childhood abuse histories and severe comorbidities such as psychosis.</td>
<td>Stabilisation phase not recommended. Trauma-focused therapies should continue to be offered to CPTSD patients. Calls for further studies on trauma therapy alone.</td>
<td>Adapted CASP checklist: Moderate. ‘Researcher allegiance’- 23 authors support trauma-focused treatment alone &amp; cite their own research. They criticise lack of a precise diagnosis in some studies in Guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dorrepaal et al. 2014 Netherlands</td>
<td>Evidence-based treatment for adult women with child abuse-</td>
<td>Review of 24 studies and then meta-analysis of 7 studies on psychotherapy</td>
<td>Results in the subgroup of childhood-abuse related PTSD</td>
<td>Affect management resulted in more favourable</td>
<td>CASP Systematic Review Checklist. Moderate/Strong. N=482 in 7 studies.</td>
<td></td>
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</tbody>
</table>
## PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

<table>
<thead>
<tr>
<th>Meta-analysis</th>
<th>related complex PTSD: a quantitative review</th>
<th>for Complex PTSD, of which 6 were CBT studies were least favourable in terms of satisfactory end states</th>
<th>recovery and improvement rates and less dropout as compared to trauma-focussed therapy</th>
<th>Patients analysed were mostly white, well-educated, employed, but had extensive abuse histories. Some recruited through adverts (i.e. not treatment-seeking) thus limiting generalisability to clinical setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fallot et al. 2011</td>
<td>The Trauma Recovery &amp; Empowerment Model: a quasi-experimental effectiveness study</td>
<td>Comparison of 98 women in TAU groups with 153 women in TREM groups in community settings, mostly African Caribbean women with substance misuse history. Outcome measures compared at baseline, 6 &amp; 12 months &amp; analysed through t-tests for continuous measures. Improvement in managing anxiety &amp; current stressors as well as increase in feeling safe. Also decrease in substance misuse. No difference in PTSD symptom improvement.</td>
<td>TREM shows advantage in reduction of anxiety and substance use and is therefore a promising intervention. But no improvement in PTSD symptoms.</td>
<td>CASP Cohort Study Checklist: Moderate. Not randomised. Non-equivalence of sites compared. Results credible as authors disappointed in lack of PTSD symptom improvement.</td>
</tr>
<tr>
<td>Korn 2009</td>
<td>EMDR and the treatment of Complex PTSD: a review</td>
<td>Exploration of how EMDR theory &amp; practice can be adapted for Complex PTSD using case studies</td>
<td>Focus on how EMDR includes a stabilisation phase known as Resource Development &amp; EMDR can be tailored to individual patient needs including those with Complex PTSD.</td>
<td>CASP Systematic Review Checklist: Moderate/weak. Not systematic, but has included important studies, not</td>
</tr>
</tbody>
</table>
### PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

<table>
<thead>
<tr>
<th>Literature review on EMDR for Complex PTSD</th>
<th>Installation &amp; clinical techniques for dealing with CPTSD symptoms such as emotional dysregulation and negative self-concept</th>
<th>EMDR. 20-25 sessions needed at least.</th>
<th>critically appraised. Could be seen as theoretical paper with description of clinical techniques.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lonergan 2014 Canada Literature review on CBT for C-PTSD</td>
<td>Cognitive Behavioural Therapy for PTSD: the role of Complex PTSD on treatment outcome</td>
<td>Review of 7 meta-analyses on efficacy of psychological treatment for chronic PTSD symptoms poorer treatment outcomes after CBT, &amp; review of literature on CPTSD treatment</td>
<td>Strong evidence for CBT relative to non-trauma therapy in 6 out of 7 meta-analyses but TF-CBT may not be tolerated in some patients. CPTSD symptoms are a barrier to positive outcomes. Positive results were also obtained in non-trauma-focused therapies including stress management</td>
</tr>
<tr>
<td>Schottenbauer et al. 2008a US Literature review on</td>
<td>Contributions of psychodynamic approaches to treatment of PTSD and trauma: a review of the empirical literature and</td>
<td>Review of empirical studies supporting psychodynamic approaches to complex PTSD, and includes relevant theoretical papers</td>
<td>Argues that symptoms of Complex PTSD such as interpersonal, developmental, personality problems based on</td>
</tr>
</tbody>
</table>
## PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

<table>
<thead>
<tr>
<th>Psychodynamic approaches</th>
<th>Psychopathology literature</th>
<th>Attachment may be more appropriately treated by psychodynamic psychotherapy (based on clinical judgement)</th>
<th>If treatment might work for CPTSD.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schottenbauer et al 2008b US Literature review</td>
<td>Nonresponse and dropout rates in outcome studies on PTSD: review and methodological considerations</td>
<td>Review of 55 studies of empirically supported treatment for PTSD with stringent examination of methodology</td>
<td>Dropout rates possibly due to patient characteristics and varied widely. Nonresponse rates as high as 50%. Current empirically supported treatments do not successfully treat all patients. Guidelines needed for data to help identify characteristics &amp; predictors of dropout and nonresponse. CASP Systematic Review Checklist: Moderate. No details on search strategy. Rigorous examination of methods used in studies. Sound explanation of why comparison difficult due to inconsistencies in measurement</td>
</tr>
<tr>
<td>Steenkamp et al. 2015 US Systematic review</td>
<td>Psychotherapy for military-related PTSD: a review of randomized clinical trials</td>
<td>Search of 3 databases for RCTs of psychotherapy for PTSD in veterans from 1980-2015. 891 publications identified and 36 studies included</td>
<td>In 9 RCTs of trauma-focussed therapy with 883 patients at least 49% achieved some symptom improvement. But about two-thirds still had PTSD. About one-quarter of patients dropped out of trauma-focussed therapy during treatment First-line treatment have high nonresponse and dropout rates and patients often remain symptomatic. This could be due to extended, repeated, and intense nature of deployment trauma. Patient preference should have a bigger role. CASP Systematic Review Checklist: moderate. Use of medication a possible confounder. Patient perspective not well covered. No distinction between group &amp; individual treatment.</td>
</tr>
</tbody>
</table>
# PATIENT VIEWS ON PSYCHOTHERAPY FOR CPTSD

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Location</th>
<th>Methodology</th>
<th>Findings</th>
<th>CASP Systematic Review Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ter Heide et al</td>
<td>2016</td>
<td>Netherlands</td>
<td>Literature review on treatment for refugees</td>
<td>Complex PTSD and phased treatment in refugees: a debate piece</td>
<td>Reviewed 2 systematic reviews &amp; a meta-analysis on treatment for refugees</td>
</tr>
<tr>
<td>Tribe et al.</td>
<td>2017</td>
<td>UK</td>
<td>Systematic review</td>
<td>A systematic review of psychosocial interventions for adult refugees and asylum seekers</td>
<td>Review of 40 outcome studies of psychological treatment for refugees/asylum seekers, after 5305 articles screened</td>
</tr>
</tbody>
</table>
## Table 6: Summary of findings from literature review: clinician expertise

<table>
<thead>
<tr>
<th>First Author</th>
<th>Title</th>
<th>Methods</th>
<th>Results</th>
<th>Conclusions</th>
<th>Critical appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloitre</td>
<td>The &quot;one size fits all&quot; approach to trauma treatment: should we be satisfied?</td>
<td>Reviews current research on PTSD in terms of debate on trauma focus or not, &amp; reformulates the question as: what therapies are optimal for which patients?</td>
<td>Calls for more involvement of patients in decision-making and greater variation of treatment interventions to address hierarchy of patient problems</td>
<td>Highlights the complexity of trauma, the heterogeneity of symptoms &amp; importance of treatments tailored to individuals. Calls for research evaluating the role of patient preference in treatment</td>
<td>Adapted CASP checklist: Moderate/strong. Written by senior clinician/researcher who has contributed to ICD-11, Expert Guidelines and done RCTs. Calls for greater patient involvement in research.</td>
</tr>
<tr>
<td>Steenkamp</td>
<td>True evidence-based care for posttraumatic stress disorder in military personnel &amp; veterans</td>
<td>One third to one half of veterans do not experience clinically significant symptom improvement in 12 sessions of trauma therapy &amp; even if they do, most retain PTSD diagnosis.</td>
<td>Outcome studies show heterogenous treatment outcomes. Where scientific evidence unclear, there is a grey zone of clinical practice in which available evidence alone is inadequate &amp; clinical judgement needs to be used.</td>
<td>Patients should be included in decision-making. Research is needed to reflect real world practice.</td>
<td>Adapted CASP checklist: moderate. Expert clinician/researcher who has published previously. Clear argument about what is evidence-based medicine and how it should be practised.</td>
</tr>
</tbody>
</table>
2.3 Literature Themes

Overview

There is a controversy in the literature on what kind of psychotherapy is helpful for Complex PTSD. The controversy centres on whether or not patients with CPTSD symptoms are able to benefit from treatments previously designed for those with core PTSD symptoms. A number of writers report that trauma-focused therapy alone has a poor record with complex cases, with large dropout and nonresponse rates (Dorrepaal, 2014; Lonergan, 2014). Numerous studies suggest that a phased approach is more appropriate (Classen et al., 2017; Cloitre et al., 2010; Fallot et al., 2011; McFetridge et al., 2017) and professional guidelines have been drawn up for such an approach (Cloitre et al., 2012). The development of adaptations to treatment for different population groups is described.

However, other clinicians report that trauma-focused therapy continues to provide good outcomes across different cultures (De Jongh et al., 2016; ter Heide et al., 2016). Both sides have published research to substantiate their assertions and as can be seen in the critical appraisal above, the research is difficult to evaluate because of discrepancies in the methodology, such as non-standard metrics, and heterogenous study populations. Another major concern for clinical practice is that there are difficulties in generalising efficacy results to patients commonly found in clinical practice, i.e. effectiveness. This is because many treatment studies exclude patients with complex clinical profiles including childhood abuse histories, self-harm, personality disorder, dissociation or substance misuse.

Because clinician expertise is an important aspect of evidence-based practice (Sackett et al., 1996), I have included a discussion paper and opinion piece by senior clinicians in the field about future directions for research.

2.3.1 Patient views

The literature on patient views of psychotherapy for Complex PTSD is limited and most studies are confined to the question of how to involve patients in making decisions about their treatment: shared decision-making. One decision, which has been studied, is whether patients prefer talking therapy to medication. There has also been limited research into whether they prefer talking about trauma to not talking about it. The results found in the literature
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On patient views were confined to those with a diagnosis of PTSD although it may be inferred that those with histories of childhood abuse or experiences of torture may include some who may more accurately be diagnosed with CPTSD.

A systematic review by Simiola and colleagues (Simiola, Neilson, Thompson, & Cook, 2015), of 41 studies representing over 6,000 people, on preferences for trauma treatment found a strong preference for talking about trauma, rather than other treatment. However, some of the studies reviewed by Simiola and colleagues did not involve patients seeking treatment, but asked hypothetical questions of non-clinical population groups. There was no exploration of a range of psychotherapy options or of the reasons behind people’s views.

A study by Angelo and colleagues (Angelo, Miller, Zoellner, & Feeny, 2008), which did explore reasons behind patients’ choice for psychotherapy, found that about half the women who had a history of trauma preferred psychotherapy. This was because they felt that talking about trauma was an active mechanism for change in therapy: “I need to talk about it”. For this reason, they also preferred Prolonged Exposure above CBT. However, the study was limited in numbers (n=74) and a diagnosis of CPTSD had not been made.

A study of 164 US veterans (Gilman, Schumm, & Chard, 2012) explored the role of hope for patients in psychotherapy for PTSD, in particular whether hope was a nontargeted change mechanism in the effectiveness of therapy. The study showed that levels of hope increased significantly and that PTSD symptom-severity decreased, with large effect sizes. Again, there was no diagnosis of CPTSD, although it might be that symptoms of the veterans merited it.

2.3.2 Outcome studies: Dropout, nonresponse and failure rates

Turning now to outcome studies, in a 2014 paper on CBT for PTSD, Lonergan acknowledged that although CBT is the first-line treatment for PTSD (and one of only two recommended by the NICE guidelines in the UK), “this approach does not work for all cases of PTSD” (Lonergan, 2014, p. 494). She said that Complex PTSD “might contribute to a poorer treatment response” and provided a summary of the evidence supporting this conclusion. She retrieved seven meta-analyses since 2000 examining the efficacy of psychological
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treatments for chronic PTSD and reported compelling support for CBT relative to non-trauma therapy. However, she went on to point out that many treatment studies had excluded patients with complex clinical profiles including childhood abuse histories and that this resulted in their reporting larger treatment effects. She also pointed out that dropout rates had been reported of between 0-50%, which suggested CBT may not be tolerated by some patients.

Similar findings were reported by Dorrepaal and colleagues in a meta-analysis of seven studies targeting complex PTSD or child abuse-related PTSD (Dorrepaal et al., 2014). Results in the subgroup of childhood-abuse related PTSD studies were least favourable, and affect management resulted in more favourable recovery and improvement rates and less dropout, as compared to trauma-focused therapy. A major concern again is that there are difficulties in generalising efficacy results to patients commonly found in clinical practice, i.e. effectiveness. This is because many treatment studies exclude patients with complex clinical profiles, including childhood abuse histories, self-harm, PD, dissociation or substance misuse.

Two papers from Schottenbauer and colleagues (Schottenbauer, Glass, Arnkoff, & Gray, 2008a; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008b) were included in the literature review. The first paper (Schottenbauer et al., 2008a) was the only result from a psychoanalytic perspective and included a useful survey of theoretical papers explaining a psychodynamic approach to working with trauma. There was also a review of empirical studies supporting this approach but the numbers involved in the studies were very small. The second paper (Schottenbauer et al., 2008b) consisted of a lengthy review of non-response and dropout rates in 55 outcome studies of empirically-supported treatment. The review showed a wide variation in dropout rates, and described non-response rates as high as 50%.

2.3.3. Outcome studies: Phase-based treatment

Other clinicians have argued that trauma-focused therapy can lead to worsening of symptoms or even re-traumatisation in some complex patients. They include leading clinicians in the Complex Trauma Task Force appointed by the International Society for Traumatic Stress Studies, ISTSS. The Task Force implemented a survey of 50 expert clinicians and published the ISTSS Expert Consensus Guidelines for Complex PTSD (Cloitre et al., 2012). The
results of the survey were that 84% of the 50 clinicians supported a sequenced approach as a first line treatment for Complex PTSD, and the paper recommended three stages of treatment (Table 3, p.27). Phase 1 was reducing symptoms and ensuring safety, Phase 2 was processing unresolved traumatic experiences and Phase 3 was re-integration into the community, family life and relationships. The Guidelines report reviewed nine published studies in which Complex PTSD symptoms were the targets of treatment, and seven of the studies were RCTs involving patients with histories of childhood abuse. One study compared phase-based treatment with trauma-focused therapy only and affect regulation only (Cloitre et al., 2010) and this showed that symptoms improved the most with the phased treatment.

The Guidelines mainly considered treatment for those with histories of childhood sexual abuse, and at the time they were published, there were no published RCTs of phased treatment for Complex PTSD in people exposed to torture or genocide. However, the report cited two studies which indicated that emotional stabilisation was also beneficial for this population group.

The ISTSS Guidelines and the studies they mentioned have been roundly criticised by a research group (de Jongh et al., 2016) focussing on the data reviewed in the guidelines. The criticisms levied at the Guidelines included: “the methodological rigour of the studies was …problematic. Two studies were not randomized control trials (RCTs), only three studies included an active control group, and three studies lacked follow-up assessments…the lack of a clear definition of Complex PTSD to select the studies reviewed for the Guidelines (and use of validated instruments to measure it), combined with methodological limitations of the studies included, limit the effectiveness of treatment on individuals of this target group (de Jongh et al., 2016, p.3).” The group considered 24 other studies with evidence in favour of trauma-focused therapy without a stabilisation phase and concluded that a stabilisation phase was not recommended.

2.3.4 Outcome studies: Evidence for effectiveness of trauma-focused therapy

A similar perspective on treatment is taken by ter Heide and colleagues (ter Heide, Mooren, & Kleber, 2016), focussing on refugees and asylum seekers in particular. It also challenges the ISTSS Guidelines over the recommendation
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of emotional stabilisation treatment for refugees, including asylum-seekers. The paper was a meta-analysis of five studies on the prevalence of Complex PTSD which showed that being a refugee in itself does not necessarily lead to Complex PTSD symptoms. The studies looked at treatment-seeking and non-treatment-seeking groups, comparing them to other population samples, such as those with a history of abuse. The paper also mentioned a meta-analysis that found evidence to support the efficacy of trauma-focused treatment in refugee samples. The treatments included were EMDR, culturally adapted CBT and Narrative Exposure Therapy, NET (Schauer, Schauer, Neuner, & Elbert, 2011). The paper concluded that “there is no scientific justification for the clinical practice of extensively or solely stabilising refugees (ter Heide et al., 2016, p. 6)."

2.3.5 Outcome studies: Adapted treatment models

There is a wide-ranging literature on empirical studies of treatment models for different patient populations with Complex PTSD. Models described in the literature which have not already been mentioned include those involving groupwork such as Classen (Classen, Muller, Field, Clark, & Stern, 2017), Fallot (Fallot, McHugo, Harris, & Xie, 2011), and Lee (2011). Clinicians noted that groups can provide therapeutic factors such as universality, which is the recognition of shared experiences and feelings among members. This may be therapeutic for those with CPTSD symptoms because it may serve to remove a sense of social isolation, reduce shame and raise self-esteem.

EMDR is the other NICE-recommended treatment for PTSD in the UK and the literature search resulted in a useful paper by EMDR clinician Deborah Korn (2009) reviewing EMDR adaptations for patients with Complex PTSD. She discussed the need for work with more complex patients to be phase-oriented, multi-modal and titrated. In fact, for all cases the EMDR protocol begins with ensuring the patient has sufficient emotional resources to cope with affect regulation. Korn also mentioned EMDR approaches for dissociated patients that are well theorised and elaborated, for example, Knipe (2014) and Paulsen (2009).

In the field of refugee or victims of war, an adaptation of CBT known as Narrative Exposure Therapy, NET, (Schauer, Schauer, Neuner, & Elbert, 2011) has shown some beneficial outcomes, which may be generalisable to other
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populations. This was one of the treatment models in a systematic review of 40 outcome studies with refugees and asylum seekers done by Tribe and others (Tribe, Sendt, & Tracy, 2017) that showed good evidence for the use of NET and culturally-adapted CBT, with mixed results for EMDR and standard CBT.

2.3.6 Clinician expertise: Re-defining evidence-based practice:

As mentioned in the Introduction (p.29), two senior clinicians, Steenkamp and Cloitre, who have both published RCT studies on psychotherapy for patients with CPTSD symptoms, have also published an opinion piece and a discussion paper on redefining evidence-based practice to include both clinical expertise and patient views. Their papers are included in the critical appraisal above, Table 6. In a special issue of the European Journal of Psychotraumatology on research, Cloitre (2015) asserted that PTSD treatment, development and implementation had “occurred without the substantial involvement of patients and trauma survivors, who have particular insight about their primary concerns and treatment preferences” (2015, p.1). She concluded that there was a need for research to evaluate the role of patient preference in enhancing treatment engagement, adherence and outcome.

This call was echoed by a psychiatrist working with US veterans, Maria Steenkamp (2016), who called for a more holistic research approach by incorporating the views and expertise of both clinicians and patients to reflect more accurately real-world practice. She criticized “a narrow and siloed focus on outcome data” which she felt had led to “one-size-fits-all approaches” (2016, p. E2).

In the literature, some clinicians such as Cloitre (2015) observe that the traditional RCT design is not a satisfactory methodology by which to identify optimal therapies for different and diverse patient populations, and that the patients, therapists, settings, delivery and duration of the treatment may be significantly different from that which is typical in the community. For example, in our team we see that refugees may experience practical problems such as homelessness, uncertainty about immigration status, language problems, and a ban on working. Such problems can make it difficult, if not impossible, to engage in psychotherapy. At a psychological level, they may also include a disruption of attachment networks that underlie mental health difficulties, both intra-psychically and in the outside world.
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Cloitre emphasises that it is useful to include “the full range of trauma patients that clinicians must treat, as well as taking into account ‘real world’ factors such as limited staffing, ‘no-show’ patients, and relapses into other disorders (e.g. substance abuse)...” (2015, p. 5). She points out this should lead to greater research-to-practice generalisability. This study, which takes a qualitative, participatory approach to exploring the views of patients in the community, is a response to the need for research on patient views, and the need to provide a more realistic evidence base for clinical practice.

2.4 Literature Summary

A review of the literature on the question of patient views on treatment of CPTSD led to the following conclusions:

- There is a substantial body of literature suggesting that current first-line treatment for PTSD based on exposure is not being taken up and is not leading to symptom improvement by substantial numbers in population groups with Complex PTSD symptoms.
- There is also recent literature arguing that trauma-focused therapy has the best empirical support for treatment and should continue to be offered to all patients with PTSD symptoms, including those who also have CPTSD symptoms.
- As well as research evidence, clinical judgement and expertise are mentioned in the literature, as an important aspect of evidence-based practice.
- While the third aspect of evidence-based practice is the values and preferences of patients, these have not been covered in the literature.

The research aims to address this gap in knowledge by exploring the views of patients in the community on psychotherapy for the new diagnosis of CPTSD.
3. Methodology

Overview
In this chapter I will describe the study's qualitative design and methodology, and explain the epistemological basis of different research activities. The study consisted of three inter-related research activities: interviews carried out by former patients with former patients; group meetings with the former patients who carried out the interviews; and an adjunct participant observation on the psychoanalytic model of infant observation. Theories on participatory research and participant observation are explained.

Thematic analysis was used to explore and evaluate findings from the first two research activities, while the participant observation was analysed using a psychoanalytic theoretical framework. There is a brief exploration of psychoanalytically-informed research methodology, and I go on to outline ethical considerations. I explain the selection and recruitment of participants, both those who carried out the research and those whom they interviewed. I give sociodemographic details of the participants and the psychotherapy modalities available in the setting. Finally I outline the procedure for data collection and the strategy for data analysis.

3.1 Design & Approach

The research was done in South London and Maudsley Mental Health NHS Foundation Trust where I work as a psychotherapist in an outpatient secondary care psychological therapies team.

I struggled initially to select an appropriate methodology because on the one hand I was aware of the academic requirement that a thesis should be an original piece of work done by me, while also wanting patients to have as definitive a voice as possible in answering the research question. As the research question was to explore patient views of psychotherapy for Complex PTSD in the community, I chose a design and methods to capture as fully as possible the subjective experiences of patients, while also including a participant observation from my perspective as a psychodynamic psychotherapist. I felt that such an approach respected the patients’ voices, while also articulating my own voice. The study therefore has a qualitative design featuring participatory research by patients and thematic analysis in which they had a decisive influence.
1. The main method was semi-structured interviews which were carried out by former patients with former patients.
2. I also studied the participation of former patients in the research process from their perspective, through holding meetings with them as a group. The meetings had some characteristics of focus groups in research terms. They were also intended to provide a form of clinical supervision and management during the research process, to ensure patient safety and wellbeing.
3. I included an adjunct study, a participant observation, on my perspective as a psychoanalytic psychotherapist, based on a reflective log.

Different modalities of treatment for complex PTSD are offered by the team including individual therapy, a women’s group for those with experiences of abuse, and a refugee men’s group. The research aim was to explore views on the experiences of psychotherapy, rather than to obtain detailed feedback on different modalities. Therefore, the interview questions included patient views on the treatment they had, and what they found helpful outside psychotherapy.

3.1.1 Epistemology and analysis methods

I chose to take a phenomenological approach in designing the study because such an approach focuses on lived experience and this was central to the research question which was an exploration of patient views. I understood phenomenology to derive from early twentieth century European philosophy, particularly the ideas of Edmund Husserl (Pivcevic, 2013) on the structures of experience and consciousness. I intended that such an approach would produce a detailed and textured description of how participants felt about their experiences of psychotherapy, that is, what meaning it had for them (Starks & Trinidad, 2007). I did appreciate that this may depend on how conscious the participants were of what was going on for them, given that that as a psychotherapist I conceptualise the mind as having an unconscious level too. This was another reason to implement a participant observation using a psychoanalytic theoretical framework, whereby I could explore unconscious meanings of the research process and results.
Phenomenology also seemed particularly appropriate as an approach in which “reality is comprehended through embodied experience”, as described by Starks and Trinidad (2007, p. 1374) because Complex PTSD has an important physiological aspect.

Such a phenomenological approach underpins the methodology and analysis of two of the research activities: the interviews with former patients and the group meetings with patient researchers about the research process itself. Thematic analysis (Braun & Clarke, 2006) was chosen for these two datasets.

Although there may be some contradictions in using discursive methods with a phenomenological epistemology, I did consider applying discourse analysis (Georgaca & Avdi, 2012), which could have explored the interpersonal dynamics between the patients doing the interviews and the interviewees, as well as the interaction between the patient researchers and myself. If the patient researchers had been able to make sufficient time to participate in such interpretive analysis, it could have given additional depth to their lived experience. However, I did not feel it was in keeping with a participatory approach to do it without them.

More structured approaches to thematic analysis were also considered such as grounded theory (Starks & Trinidad, 2007), which could have looked at the social processes involved in the research and its context. Again, however, I felt it would involve too great a time commitment from the researchers as they sometimes struggled to attend the interviews and meetings that had been arranged. I was also uncertain that grounded theory would produce findings relevant to the research question.

### 3.1.2 Two-stage thematic analysis for interviews

In thematic analysis, the usual process is that the researcher codes interesting features of the data in a systematic fashion and then collates codes into potential themes (Braun & Clarke, 2006). However, in keeping with the participative, collaborative approach taken in this study, I wanted to ensure that the researchers’ views were influential in deciding which themes were selected. I could have collaborated with them in coding, but this would have taken more time than was feasible.
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Therefore in order to take a systematic approach, I held an analysis meeting with the researchers and implemented an inductive thematic analysis of the transcription of the meeting (See Appendix L for a transcript of part of the meeting). I then used the themes they generated to search the interview transcriptions for relevant data extracts (See Appendix N for example of NVivo coding).

Table 7. Procedure for thematic analysis

<table>
<thead>
<tr>
<th>Data sets</th>
<th>Analysis stages</th>
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<tbody>
<tr>
<td></td>
<td>Stage 1.</td>
</tr>
<tr>
<td></td>
<td>Researchers select themes</td>
</tr>
<tr>
<td>Researcher meeting transcripts</td>
<td>I code data extracts and refine themes</td>
</tr>
<tr>
<td>Interview transcripts</td>
<td>Researchers select themes</td>
</tr>
<tr>
<td></td>
<td>I code data extracts and refine themes</td>
</tr>
</tbody>
</table>

This was a more theoretical approach to thematic analysis, rather than data-driven. An attempt was made to ensure the process was thorough, inclusive and comprehensive, and not anecdotal (Braun & Clarke, 2006). The meeting had some similarities to a focus group, which will be discussed further below, and we did not examine the transcriptions in detail as would have been done in a joint coding exercise. I felt it would give more relevant answers to the research question if the researchers were able to give a subjective response, rather than focusing on frequency of issues mentioned. This was because the interviews were based on pre-selected questions, mostly devised by me, and I wanted the researchers to be able to identify freely what emerged from their interviews about patient views for psychotherapy for CPTSD.

3.1.3 Thematic analysis for research process

I also applied thematic analysis to the research process itself from the perspective of the patient researchers, using a similar procedure. Themes were selected at the analysis meeting with the six researchers and I then coded relevant extracts from transcripts of group meetings. (See Appendix L for Transcript of the analysis meeting Part1). The group meetings with
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Researchers had a dual function with both clinical and research aims and this is explained below (Section 3.3 p.58).

3.1.4 Analysis of participant observation

A psychoanalytic theoretical framework is the epistemological basis for the analysis of the participant observation and in this context is viewed as phenomenological. The analysis was applied to the reflective log I kept during the research process. I searched through it for notes and events relevant to patients’ views of treatment, my experience as a clinician researcher, and to a psychoanalytic understanding of attachment and object relations theory.

As explained above, a participation observation was implemented that explored my own emotions and behaviour to provide clues to what may be going on for others, as well as observing others. Therefore, as well as the application of psychoanalytic thinking which focuses on the unconscious, it also includes reflexivity in the sense used in social science: how my presence may have affected the analysis. It was also useful for triangulation purposes, that is, where a different theoretical model is used to look at the same data. Braun and Clarke are critical of “a naïve realist approach” (2006, p. 7) where a researcher can simply give voice to their participants, and I intended that adding a psychoanalytic perspective would give greater depth to the thematic analyses.

It is necessary to say here that the application of psychoanalytic theory to research methodology and analysis is a contested and complex field. For instance, some writers (Frosh, 2010) feel that psychoanalytic ideas, which are based in clinical practice, may not be applied in a research context. This criticism is particularly levied at methods such as research interviews that claim to replicate aspects of the interaction in the psychotherapist/patient dyad.

Other writers, especially those influenced by Lacanian thinking, argue that social constructionist ideas about epistemology may be more in keeping with psychoanalysis because it draws on a biographical-interpretative model of understanding people (Midgley, 2006). I want to clarify that in this study a psychoanalytic methodology was used only in the participant observation and that it was based on a phenomenological epistemology underpinned by attachment theory. I will first address relevant theory in participatory research methodology, including liberation psychology, the service user movement, and how attachment theory may be congruent with these methods.
3.2 Participatory research theory

As mentioned in the Introduction (see 1.7.1, p. 20), there is a wide-ranging literature on participatory research in health and other fields, such as community development. Early writers such as the Brazilian educator, Paolo Freire (1968/2000) and the Salvadoran social psychologist, Ignacio Martín-Baró (1989) were interested in promoting popular participation in research as a means to empowering marginalised social sectors. In the UK in the 1990s, this conceptualization was elaborated by a growing service user movement in mental health. The service user movement felt that health professionals’ understanding of what constituted evidence (with its emphasis on RCTs) had become too powerful at the expense of service users’ knowledge based on their experience (Rose, 2003; Rose et al., 2006). They pointed out that service user input into research could result in more effective treatment that would correspond more closely with patients’ needs and preferences. In research terms, it may also lead to fuller and more honest information if patients feel more able to disclose their views to other patients.

The literature on participatory research in health divides methods into three categories: user-led research, collaboration and consultation (Nierse, Schipper, van Zadelhoff, van de Griendt, & Abma, 2012). This study comes under the category of collaboration between service users (experts by experience) and professionals (experts by learning).

I want to note here that psychoanalytic theory based on attachment in the social arena is highly relevant to participatory research. As mentioned above, psychoanalyst Martin Seager has written a powerful and moving paper on how to promote “safe, sound and secure” mental health services (2006, p. 266), in which he highlights how external object relations are key to mental health. He emphasises the need “to feel connected to other human beings socially in a way that affords a sense of belonging, identity, shared meaning and purpose” (Seager, 2006, p. 271). This conceptualisation of attachment may be seen in the organisation of a research network of service users to promote recovery by Springham and others (2011) in a neighbouring south London NHS Trust. I intended that a participatory approach would have similar benefits for participants in my study in terms of their recovery. I will now explain how the participatory approach was implemented through group meetings with former patient researchers.
3.3 Dual Function of Research Group Meetings: Clinical and Research

During the research process, regular meetings were held with the patient researchers. The first aim of the meetings was to ensure that the researchers were implementing the interviews in an ethical and an effective way, as well as to support their own emotional well-being and learning. This aim is similar to the clinical and management supervision ideally provided for clinical staff. There were both practical and ethical reasons for this, which are described below. The second aim was to collect data on the patient researchers' views, both of the interviews they carried out and their participation in the research process itself. The last meeting held, which I have called the research analysis meeting, was particularly intended to fulfil the second aim. In this it had some commonalities with the aims and characteristics of the focus group method, which I will now describe.

Focus groups are intended to decrease the power and control of the researcher, in that the group setting can empower participants to speak out (Smithson, 2008). A focus group can constitute a collective and collaborative effort. This was in keeping with the participatory approach chosen for the study, and in particular addressed the unequal power dynamics between myself as both psychotherapist and researcher, and the former patients in the service who were implementing data collection and analysis as researchers. This was especially important in the research analysis meeting where the patient researchers discussed together and identified the themes they felt were significant in the interviews they did. They also discussed their experience of the research process itself and identified important themes for analysis from that process.

Bowling says that focus groups “can be used to examine not only what people think, but how they think and why they think in that way, their understandings and priorities (Bowling, 2014, p. 411).” This fuller understanding of how participants viewed their psychotherapy may have significant implications for future clinical practice and service design.

In summary, participatory research by service users was chosen for three reasons. Firstly, service users have a wealth of experience that can be tapped to help design the interview questions and analyse the results (Rose, 2003). Secondly, service user participants may be able to relate to service user
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researchers more fully and openly than to professionals in the implementation of semi-structured interviews (Thornicroft, Rose, Huxley, Dale, & Wykes, 2002). Thirdly, it may be helpful to service user researchers who have traumatic interpersonal experiences to be able to connect socially with others in a shared purpose, the research project (Seager, 2006).

3.4 Clinician Participant Observation and Reflexivity

I also included in my research an adjunct participant observation from my perspective as a psychotherapist and researcher, and the epistemology which underpins this merits elaboration. I have mentioned above (see 1.5.2, p.16) that there were tensions in designing and implementing a research study using psychoanalytic theory. In his book “Researching the Unconscious”, Rustin (2019) considers some of these tensions. He discusses the different approaches adopted by qualitative and quantitative researchers towards their studies, pointing out that the human sciences study objects (people) who are capable of self-reflection and self-interpretation. He says that the “idea that the interpretation of 'subjective' or cultural meanings is an essential element of a sufficient explanation has remained central to sociology” and he compares this to the way psychoanalysts approach their clinical work: “What psychoanalysts mostly do is, after all, to try to understand the meanings of their patients’ communications, whether these are made in words, play, gesture, behaviour, or as they are understood through the “countertransference”— that is to say, when an analyst infers that her own state of mind may be reflecting unconscious communications from the patient (Rustin, 2019, p.66)

Before clarifying my understanding of countertransference below, I will first clarify my use of the term “participant observation” in this study. Research methodology manuals generally describe participant observation as a type of ethnography that adheres to the philosophy of phenomenology. For instance, Bowling describes participant observation as an “observational technique which involves the observer (researcher) in the activities of the group being observed...It is the best method for understanding the experiences of people, and the meanings they attach to them” (2014, p. 372). However, in psychoanalysis the activity of participant observation has a particular meaning and history that is derived from the clinician’s dual role as both a professional, and a participant in the treatment. Psychoanalyst Esther Bick explained that
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the early use of participant observation in infant observation was first designed as “an adjunct to the teaching of psycho-analysis and child therapy, rather than as a research instrument” (1964, p. 558). It was important, Bick said, that “the observer should feel himself sufficiently inside the family to experience the emotional impact (1964, p. 558)” This can be seen as using the observer’s subjectivity to give clues to the experiences of others.

Bell and Leite describe this as “like seeing a lens while you see through it” (Bell & Leite, 2016, p. 29). Psychoanalytic participant observation thus involves the observers in explicitly analysing the experiences that they observe, both in themselves and those they are observing, using psychoanalytic theory to do so. The approach has been criticised by some qualitative researchers, as Midgley points out (2006), because psychoanalytic theory is based on the assumption that beneath the spoken word there is an unconscious process going on, which the clinician interprets and analyses. Critics (for example Frosh, 2010) say that this privileges the perspective of the observer at the expense of other participants and view it as a “top-down” approach. Psychoanalytic theory has conceptualised the analyst’s subjectivity in the clinic as countertransference and this term has been used in different ways since it was first coined by Paula Heimann in 1950 (Heimann, 1950).

In the research field, Holmes (J. Holmes, 2014) highlights that in the past countertransference has frequently been interpreted by researchers in the Kleinian sense to mean emotions invoked in the researcher by the participant’s defences. Holmes describes this understanding of countertransference as reinforcing “the myth of the infallible therapist” (2014, p.170) which seems to be “the antithesis of a reflective stance” (2014, p.177).

Holmes (2014) sees countertransference in research as a co-created phenomenon evolving in an intersubjective field, following the perspective taken by Ogden (1994) in his exploration of countertransference in the therapeutic relationship. This is the understanding which I have followed in this study. Moreover, just as in psychoanalysis the therapist has to ground interpretations on clinical material that is confirmed by the patient (Britton & Steiner, 1994), so in research there needs to be evidence in the data for the findings. The participant observation provides data for such findings in this study.

In a more recent study, Holmes elaborates in his book (2018a) how the researcher’s feeling and bodily states may be seen as co-created in the
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intersubjectivity between participant and researcher. He compares this to the psychoanalytic concept of reverie developed by Bion (see 1.8.5, p.23) and describes how it may be used in a research interview. Although his Reverie Research Method (RRM) is mainly applicable to individual interviews, Holmes’ emphasis on the intersubjective creation of researcher experience may be relevant to this study. One reason for this is that it resonates with the conceptualisation of attachment as an interpersonal process.

I argue that the researcher’s subjectivity is implicated in all observation and that by explicitly analysing the experience of the researcher, a psychoanalytic approach to participant observation attempts to make that role open to scrutiny, through a psychoanalytic lens. Such subjectivity as I have applied it in this study includes countertransference, in the sense of initially unconscious responses which may be co-created in the intersubjective field between me and the participants. This seemed particularly necessary to explore as I had already had a clinical relationship with some of the participants who were former patients. I understood therefore that there was an existing countertransference because of this relationship which was relevant to the study and this is explored in the analysis of the participant observation. (see pp.

Hollway and Jefferson say that a psychoanalytic epistemology and methodology “enhances an ethical stance (2000, p. 165)” because it requires a courageous openness to subjectivity. They see subjectivity as an instrument of knowing and a resource for understanding, and I hope to use my subjectivity in this same way, with the additional use of psychoanalytic theory, including countertransference. Through describing this as a participant observation, I acknowledge the dataset as my perspective, rather than a neutral framework. In this way I intended to counteract what Holmes describes as “the myth of the infallible therapist (2014, p.170).”

Midgley (2004) and others also argue that psychoanalytic theory and thinking is useful in research because it goes some way towards explaining not only the meaning of what people say, but also why they say it. I felt this was important for my research because it could provide additional depth in the phenomenological approach taken to analysing the findings of the interviews and meetings with service users. I felt it would give the findings more weight if, as well as answering the research question on what were their experiences of
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psychotherapy, there could be some indications of why people felt that way, because there could be implications for clinical practice.

The purposes of the participant observation were:

- To make explicit my role as a psychotherapist in the research in the interests of transparency, including an exploration of countertransference (defined here as a co-creation between myself and the participants)
- To enrich the analysis of the interviews and group meetings and supplement them with a psychoanalytic perspective based on attachment theory

3.5 The Research Setting

I will now describe the research setting to explain its context. In common with many UK inner city suburbs, the south London borough of Lewisham has high levels of poverty, according to the Department for Communities and Local Government’s 2015 Index of Multiple Deprivation, IMD, cited in the Lewisham Poverty Commission report (2017). The IMD measures relative deprivation across 7 domains: income; employment; education, training and skills; health deprivation and disability; crime; barriers to housing and other services; and the living environment. Out of 326 local authorities, Lewisham ranked 48th in levels of deprivation. Housing is a particular problem in the borough, as it is throughout London, where rents have risen fast and there is an acute shortage of public and social housing. Lewisham is also one of the most ethnically diverse in the UK with 46.4% of the population from a black, Asian or minority ethnic background, according to the 2011 Census (Lewisham Borough Council, 2018).

The sampling frame comprises a secondary mental health team, the Integrated Psychological Therapies Team, IPTT, which is run by the south London and Maudsley NHS Mental Health Foundation Trust, SLaM. The team is based at University Hospital Lewisham and accepts an average of 378 referrals per annum (2013-2017) of patients diagnosed with anxiety, depression, or personality disorder, of a complexity that cannot be treated in primary care. The referrals come from the borough primary care service, Improving Access to Psychological Therapies, IAPT, or from the Assessment and Liaison teams, which assess and refer on patients with complex mental health needs. The team has 9 whole time equivalent (wte) clinical posts,
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providing therapies which include group, systemic, psychoanalytic, Cognitive Analytic Therapy, Cognitive Behavioural Therapy (CBT), and Eye Movement Desensitisation and Reprocessing (EMDR). Two part-time therapists (1.5 wte) offer treatment for Complex PTSD and both have two trainee psychologists or psychotherapists on one-year placements.

An average of 75 patients a year (2013-17) out of the 378 annual accepted referrals to IPTT were assessed by psychotherapists specialising in trauma, including myself, as they presented with difficulties which included PTSD symptoms. As patients with core PTSD are expected to be treated in primary care, patients referred to secondary services inevitably have more complex, long-standing symptoms. Most patients with Complex PTSD symptoms in Lewisham are therefore referred to the team, although some people with co-morbid disorders may be referred to other specialist services such as those working with substance misuse. Patients with psychosis are not seen by the team, although it may be that some patients experience psychotic symptoms from time to time, such as hearing voices. The ethnic origins of patients seen by the team in 2017 mirror the borough’s population almost exactly with 54% being white British and 46% being from other ethnic groups. In terms of gender in 2017, 65% of patients were female and 35% male and the mean age of patients was 35 years.

3.6 Ethical Approval and Considerations

Ethical approval was sought from the Health Research Authority, HRA, which is part of NHS England. The research required NHS Research Ethics Committee review because it involved participants identified from past or present use of NHS services. It was submitted to the Westminster Research Ethics Committee on August 29, 2017 and approved (see Appendix C) with the recommendation that all participants be sent a transcript of their interview and invited to comment further if they wished. This was because the Committee felt that the time allocated for the interviews, which was one hour, might not be long enough for participants to give their views in full. The Participant Information Sheet had to be amended as a condition of approval, which was confirmed formally on Sept.12, 2017 (see Appendix D p.144).

There were a range of ethical concerns that had to be addressed in the implementation of the study, including the care and payment of those patients
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doing the research, as well as those being interviewed by former patients. I also saw it as an ethical issue that patients who did not speak English had an opportunity to contribute to the study, particularly since 27% of our patients overall are from Sri Lanka and most are not fluent English-speakers. There may also be ethical concerns about the financial exploitation of patient researchers and a budget was secured to pay them. I will explain below how these ethical concerns were addressed.

3.6.1 Ethics of involving my former patients in research

The ethics of implementing a research project involving some of my former patients in the study were of such significance that I described the main concerns in the Introduction. They included the possibility of systematic bias, the conflicts and coincidences in the roles of researcher and clinician, and the unequal power dynamic between former patients and myself as researcher and professional. These concerns were addressed in the design and methods of the study, particularly the participatory approach and the participant observation. I want to address here the possibility of harm to the mental health of former patients by engaging with me in a research context. The British Psychoanalytic Council (BPC) with which I am registered, has a Code of Ethics that states that registrants “must at all times act in a way that they reasonably believe to be in the best interests of their patients.” This research was undertaken to benefit patients of the future by studying what was felt to be helpful by patients of the past. It was also intended that participating in research would promote the recovery of those who participated. This was found to be the case as is explained below (4.3 Analysis of Research Process p. 93).

3.6.2 Ethics of former patients implementing research

The ethics of patient care are an important part of any professional training, where clinicians are trained in ethical conduct and procedures such as safeguarding, confidentiality, personal limits and financial probity. In order to ensure that participants were protected, it was necessary to provide training for service user researchers in these ethical issues, as well as to ensure that they had completed the necessary police checks for working with vulnerable people through the Disclosure and Barring Service, DBS. The SLaM Volunteer Development Co-ordinator provided this training, as well as processing DBS checks before data collection began. Being a trained SLaM volunteer also
meant that the research activities could count as work experience for which a reference could be provided, thus helping participants into employment if they wished. Some of the researchers had not worked for some years.

3.6.3 Patient after-care

The researchers made clear before the interviews that personal histories should not be disclosed as the research was interested in patient views on psychotherapy or other helpful factors. This was also made clear in the Patient Information Sheet (see p.144). However, if participants had become disturbed by the interviews, a psychotherapist colleague was available to meet participants and the researchers were aware of this. No participants used this facility. All interviews were held on clinical premises during working hours.

The researchers were also former service users and therefore may have been vulnerable to emotional disturbance when discussing treatment with participants. Regular post-interview meetings were organised for them at which such issues could be discussed. One-to-one meetings with a clinician were also available, either myself or another psychotherapist. One researcher used this offer for a brief conversation about her feelings around identifying with the first interviewee.

3.6.4 Access for non-English speakers

I saw it as an ethical issue that the research did not exclude the views of non-English speakers. The majority of patients seeking treatment for Complex PTSD in Lewisham have English as a second language, although most speak adequate English for psychotherapy treatment. Translation was available for any participant requiring it to do an interview and an interpreter was used with 5 participants. Four of these were Tamil refugees from Sri Lanka. The list of questions was translated into Tamil (Appendix E, p.146) and sent to Tamil-speaking interviewees before their interviews. Lewisham has a high concentration of resident Tamils and there have been 122 referrals of refugees from Sri Lanka seeking treatment with the team for Complex PTSD since 2012. As such, they form the largest single ethnic group that has been in treatment and it was important that the research included their views. One further participant required a Vietnamese translator for her interview. Unfortunately, it was not possible for asylum-seekers to get the certification
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from the Disclosure and Barring Service, DBS, necessary to work with patients as a SLaM volunteer.

3.6.5 Budget for participant payment
The National Institute for Health Research, NIHR, funds a national advisory group, INVOLVE, which supports greater public involvement in NHS research and it has published a useful guide for cost estimation: “Budgeting for involvement: Practical advice on budgeting for actively involving the public in research studies” (INVOLVE, 2013). Service user researchers were paid for doing the interviews, but not for training or discussion time. The London Living Wage, which was £9.75 an hour, was taken as a benchmark and I decided to pay £10 an hour. Exeter University’s Post Graduate Research funding provided £470 for participant payment expenses.

3.7 Preliminary Consultation with Staff and Patients
Patient consultation was an integral part of the research from the beginning as patients were collaborators, as well as participants. I had an initial meeting in February 2017 with the Patient and Public Involvement Co-ordinator at the Service User Research Enterprise in the Institute of Psychiatry, Psychology and Neuroscience. This provided some useful advice on initial steps to involve service users in the design of the study from the beginning. When I was designing the study, there was an existing group of former patient volunteers in the team who carried out peer support activities with former and existing patients. This group had some early input into research design and patient information materials. I then presented the research plan and information sheet drafts to a staff meeting on May 3, 2017 where there were some helpful suggestions to clarify the content. After the research was approved by the Research Ethics Committee, I met two other staff members, the Patient Involvement Manager and the Volunteer Service Development Co-ordinator for advice on training service users in research. The Co-ordinator agreed to train the researchers as SLaM volunteers and process the necessary police checks, which was crucial in enabling them to carry out interviews with former NHS patients.
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3.8 Participant Selection: Interviewees and Researchers

There were two types of participants in the study: those recruited to participate in the research design, data collection and analysis, and those recruited to be interviewed about their experiences of treatment. After the researchers were recruited, they decided that they would first interview each other to ensure that they had their own input into the research as former patients. This meant they were interviewees as well as researchers. There were six patient researchers who were also interviewees and 18 former patients whose participation consisted only of being interviewed. In total, a purposive sample of 24 former patients took part in the study. They were selected from a total of 235 referrals to the trauma service over three years between October 2014-September 2017.

All had a diagnosis of Complex PTSD at assessment as defined by ICD-11. This was measured by scores on IES-R (Weiss, 1997) which is a screening measure for core PTSD administered at assessment. I also searched narrative assessments to identify the additional three symptom clusters for Complex PTSD described in ICD-11: difficulties in regulating emotions, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships. Prior selection criteria were:

- Completed at least 12 sessions of therapy
- More than 12 weeks since end of therapy
- Not in treatment with another team
- Currently resident in Lewisham
- Not currently unwell in opinion of treating clinician

The reasons for the selection criteria were as follows. I decided that a minimum of 12 sessions of therapy was a reasonable time period for patients to be able to give a view on psychotherapy for Complex PTSD. Most of the 24 participants had experience of at least six months of treatment with the team. The reason for waiting 12 weeks after the end of treatment is that some evidence suggests patients may be vulnerable soon after ending treatment (Richards & Schwartz, 2002). In order to have as realistic view as possible of patient profile, patients with co-morbid disorders including dissociation, substance misuse, or personality disorder were included. Only those patients still living in Lewisham were included as there were no travel expenses to
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reimburse those who had moved. There were two exclusion criteria. I did not invite patients in treatment with other teams as it could have interfered with their treatment. The other exclusion criterion was if patients were too unwell to participate as advised by the clinician who had treated them, or decided by the patients themselves on invitation. This included both physical and mental health.

3.8.1 Researcher selection criteria.
In addition to the selection criteria for participants above, there were two extra criteria for recruiting researchers:
- Not currently in employment
- Sufficient English to take part in researcher training

The reason for inviting those not in employment was because I wanted to offer a training opportunity to people who were not working, and did not want to take up the time of those who had a job. I did not always know before contacting them whether they were working or not. An ability to communicate in English was also necessary for researcher selection because it was not possible to provide a translator for the training sessions. (This did not prevent participation by those who did not have English as a first language, who comprised three out of the six researchers.)

3.9 Researcher Recruitment and Training
3.9.1 Researcher recruitment
Twenty-seven invitation letters (Appendix F, p.148) and the Researcher Information Sheet (Appendix G, p.149) were sent out to possible researchers who fulfilled the criteria, and I then sent follow-up e-mails and made phone calls to discuss the research and answer any questions. Eleven of those invited were from Sri Lanka, reflecting the high concentration of Sri Lankan Tamil refugees among patients referred, but none wanted to take on the researcher role. Some were working, but others did not give a reason for not wanting to participate. Seven people said they wanted to take part. One was working part-time in a job she did not like that involved a high risk of physical violence. I agreed to her taking part so that she might be more able to find other employment by learning different skills through the research. Other patients who were already working were unable or unwilling to participate.
3.9.2 Researcher training and design input.
I held a training session for the service user researchers at University Hospital Lewisham in November 2017, which began with a discussion on the reasons for the research and service user involvement in it. We discussed the interview questions I had drafted and a revised version was agreed to reflect their views (see Appendix M, Interview Schedule, p.174), after they had done practice sessions with each other. The changes made were not substantial. We decided to send out the list of questions before the interviews so that participants would know in advance what to expect. They also approved the Participant Information Sheet (Appendix D, p.144) and the Consent Form (Appendix H,p.152). There was a particular emphasis on how to invite people to talk about their experience in psychotherapy, without disclosing details of their personal story, which could have been disturbing for both researchers and interviewees.

3.9.3 Interview training
There was a practical session during the training when people practised using the digital voice recorders (three were provided) and interviewed each other. There was a role play and discussion on how to help interviewees feel relaxed and talk freely, without going into traumatic events. The researchers read and signed the consent forms themselves at the session, before I began to record it, and this was useful in learning how to administer the forms to other participants.

At the end of the session, there was preparation for the SLaM volunteer training and an explanation of the documents needed for the DBS check. Seven researchers attended the training, but the following day one of them left a telephone message to say she did not want to participate after all. I returned the call, but she did not answer or call back, so her reasons are not known. The remaining six people took part in data collection and analysis.

3.9.4 SLaM volunteer training for researchers
This training was delivered by the Volunteer Co-ordinator and a SLaM volunteer, who was a former service user, in the regular format used by them for all volunteer training. The topics covered were:
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- An introduction to volunteering within the Trust
- Communication and listening
- Mental health issues
- Boundaries and confidentiality
- Safeguarding

Case studies were used to enable people to think about real situations that might arise to make their learning more meaningful. This training was crucial in equipping the patients researchers to carry out the interviews in an ethical and effective manner.

3.10 Participant Recruitment for Interviews Only

After the researchers had agreed to participate and their training was scheduled, I recruited the participants to be interviewed according to the selection criteria outlined above. Invitation letters (see Appendix J. p.153) were sent to 69 patients chosen in chronological order from 235 former patients who were referred to the trauma service from 2014-2017 with those referred most recently first. Some people who had been contacted about the researcher role were contacted a second time, either because they had expressed an interest in participating in the interviews only or because they had not responded to letters and we had other contact details.

The most common reasons for exclusion were: not having engaged for at least 12 sessions, and still being in treatment. More of those selected were referred in 2014-16 because many of those who were referred in 2016-17 were still in treatment. I sent out a Participant Information Sheet (Appendix D) and a Participant Invitation Letter (Appendix J) by post unless an e-mail was preferred by the patient. I then called or e-mailed each one to discuss the research. If they agreed to participate, I then sent each one a confirmation letter with the list of questions as above.

3.11 Participant Sociodemographic Data (researchers and interviews)

I collected brief quantitative data to provide descriptive statistics on the participants that were not analysed statistically. Table 8 below shows age, gender, ethnic origins, first language, number of sessions, and type of therapy offered to all 24 participants, both researchers and those who did interviews.
PATIENT VIEWS ON THERAPY FOR CPTSD
only. Researcher 4 attended training but decided not to participate in the research.
Table 8: Characteristics of participants (n=24)

<table>
<thead>
<tr>
<th>Participant ID</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnic origins</th>
<th>First language</th>
<th>Number of sessions</th>
<th>Type of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher 1.</td>
<td>female</td>
<td>55</td>
<td>Black British</td>
<td>English</td>
<td>60</td>
<td>Women’s group</td>
</tr>
<tr>
<td>Researcher 2.</td>
<td>female</td>
<td>40</td>
<td>Middle Eastern/British</td>
<td>Arabic/English</td>
<td>45</td>
<td>Women’s group &amp; individual</td>
</tr>
<tr>
<td>Researcher 3.</td>
<td>female</td>
<td>57</td>
<td>White British</td>
<td>English</td>
<td>35</td>
<td>Women’s group</td>
</tr>
<tr>
<td>Researcher 4.</td>
<td>Withdrew</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researcher 5.</td>
<td>male</td>
<td>71</td>
<td>Latin American</td>
<td>Spanish</td>
<td>17</td>
<td>NET</td>
</tr>
<tr>
<td>Researcher 6.</td>
<td>female</td>
<td>40</td>
<td>Black British</td>
<td>English</td>
<td>60</td>
<td>Women’s group</td>
</tr>
<tr>
<td>Researcher 7.</td>
<td>male</td>
<td>40</td>
<td>Congolese</td>
<td>Lingala/French</td>
<td>74</td>
<td>EMDR</td>
</tr>
<tr>
<td>Patient A</td>
<td>female</td>
<td>43</td>
<td>White British</td>
<td>English</td>
<td>45</td>
<td>EMDR</td>
</tr>
<tr>
<td>Patient B</td>
<td>female</td>
<td>37</td>
<td>Vietnamese</td>
<td>Vietnamese</td>
<td>44</td>
<td>NET</td>
</tr>
<tr>
<td>Patient C</td>
<td>female</td>
<td>44</td>
<td>Somali</td>
<td>Swahili</td>
<td>22</td>
<td>Systemic</td>
</tr>
<tr>
<td>Patient D</td>
<td>female</td>
<td>51</td>
<td>Black British</td>
<td>English</td>
<td>46</td>
<td>Women’s group</td>
</tr>
<tr>
<td>Patient E</td>
<td>male</td>
<td>33</td>
<td>Sri Lankan</td>
<td>Tamil</td>
<td>24</td>
<td>Men’s group</td>
</tr>
<tr>
<td>Patient F</td>
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<td>Sri Lankan</td>
<td>Tamil</td>
<td>30</td>
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</tr>
<tr>
<td>Patient G</td>
<td>female</td>
<td>47</td>
<td>Black British</td>
<td>English</td>
<td>38</td>
<td>Women’s group</td>
</tr>
<tr>
<td>Patient H</td>
<td>male</td>
<td>61</td>
<td>Kurdish/Syrian</td>
<td>Kurdish/Arabic</td>
<td>24</td>
<td>NET</td>
</tr>
<tr>
<td>Patient J</td>
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<td>Sri Lankan</td>
<td>Tamil</td>
<td>18</td>
<td>Men’s group</td>
</tr>
<tr>
<td>Patient K</td>
<td>male</td>
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<td>Sri Lankan</td>
<td>Tamil</td>
<td>21</td>
<td>Men’s group</td>
</tr>
<tr>
<td>Patient L</td>
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<td>45</td>
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<td>Japanese</td>
<td>43</td>
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</tr>
<tr>
<td>Patient M</td>
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<td>63</td>
<td>White British</td>
<td>English</td>
<td>12</td>
<td>EMDR</td>
</tr>
<tr>
<td>Patient N</td>
<td>male</td>
<td>57</td>
<td>Congolese</td>
<td>Lingala/French</td>
<td>60</td>
<td>Systemic</td>
</tr>
<tr>
<td>Patient O</td>
<td>female</td>
<td>28</td>
<td>White British</td>
<td>English</td>
<td>22</td>
<td>Systemic</td>
</tr>
<tr>
<td>Patient P</td>
<td>male</td>
<td>43</td>
<td>Spanish</td>
<td>Spanish</td>
<td>50</td>
<td>EMDR</td>
</tr>
<tr>
<td>Patient Q</td>
<td>female</td>
<td>47</td>
<td>Ugandan</td>
<td>Luganda</td>
<td>21</td>
<td>CBT</td>
</tr>
<tr>
<td>Patient R</td>
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<td>Congolese</td>
<td>Kinyarwanda/French</td>
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<td>EMDR</td>
</tr>
<tr>
<td>Patient S</td>
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<td>59</td>
<td>White British</td>
<td>English</td>
<td>24</td>
<td>Integrative</td>
</tr>
</tbody>
</table>


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3.11.1 Descriptive statistics

The reason for collecting statistics about the participants was primarily to understand more about the characteristics of people in a community setting in an inner London borough presenting with Complex PTSD. The information showed the diversity and range of patients with the diagnosis. This was important in exploring the research question, which was about patients views of treatment. I collected these statistics from electronic patient records and my own records of annual referrals.

Gender & sexuality: There were 14 women and 10 men (gender at birth) who took part in the study, which is a higher proportion of men than accessed the IPTT service in 2017. 42% of study participants were men compared to 35% attending for psychotherapy in general. There were two homosexual participants and one transgender participant.

Age: Average age of the participants was 45.5 years which is 9.5 years older than the average for all patients accessing Lewisham IPTT in 2017.

Ethnic origins & language: Only five of the 24 participants, or 21%, were white British compared to 46% of all patients accessing treatment. This may reflect the origins of some of those with Complex PTSD who came from global conflict areas such as Sri Lanka (four people) and the Democratic Republic of Congo, DRC, (three people). There were also four women who came from Jamaica, or had a parent who did. The reasons for this are beyond the scope of the present study.

Treatment length and modality: Treatment length varied from 12 sessions to 74 sessions with an average of 36.5 sessions. Twelve out of the 24 participants had attended groups, and some had experienced additional individual treatment. Participants were not asked about treatment before Lewisham IPTT although a number had had therapy previously. There were two types of group offered: a men’s group for Sri Lankan Tamil refugees, and a women’s group for those who had experiences of childhood sexual abuse. Individual modalities included: Cognitive Behavioural Therapy, CBT, Eye Movement Desensitisation and Reprocessing, EMDR, Narrative Exposure Therapy, NET, systemic and integrative approaches.

No attempt was made to measure numerically the outcomes for each modality in the present study, which focused on qualitative patient experiences of treatment. CBT, systemic and integrative approaches are well explained in
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accessible manuals. It should be noted, however, that some individual patients were treated with a systemic approach. Further details are given below of the four most popular treatment modalities used with the participants.

3.12 Treatment Modalities

3.12.1 Women’s group.

Lewisham IPTT offers a specialised therapy group for women with experiences of childhood sexual abuse. The group is currently based on a model devised in the US called the Trauma Recovery and Empowerment Model, TREM, a manualized group intervention designed for women trauma survivors with severe mental disorders (Harris & Anglin, 1998). The group’s content and structure are informed by the role of gender in the ways women experience and cope with trauma. Attachment theory underlies the consideration of relationships, which is a major focus of the group, and especially useful for those whose diagnosis is a result of human mistreatment, as described in the new ICD-11 diagnosis (WHO, 2018).

Psychotherapists in Lewisham were supervised by a clinician in Washington DC to adapt the model for use in London. The group consisted of weekly sessions of 90 minutes over 15 months. It had earlier been limited to nine months, but this was extended after research when former patients suggested this was not long enough. Stabilisation techniques were also taught as part of the women’s group.

3.12.2 Men’s refugee group

Although the civil war in Sri Lanka ended in 2009, refugees from the persecuted Tamil minority have continued to come to Lewisham because of links with the existing community in the borough. Many are young men aged between 20 and 40 years seeking treatment for PTSD symptoms resulting from detention and torture, including sexual assault. Most have applied for asylum in the UK and spend some years waiting for resolution of their immigration status. This makes it difficult to carry out trauma-focused therapy, which relies on the patient feeling safe in the present. Therefore we have devised a group model for Sri Lankan Tamil men only, which is run in conjunction with a local community garden project, Sydenham Garden.

The group consists of up to 10 members over 20 weekly sessions of two hours, where the first hour includes garden activities such as planting or
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building small structures, such as a greenhouse, and the second hour is run by a psychotherapist with a Tamil translator. The talking group includes psychoeducation about PTSD, as well as stabilisation techniques, and some time for group members to express feelings about their situation and receive support. Peer support is an important element of the group as social isolation is a particular problem for asylum seekers who are not permitted to work and are often actively under threat of deportation.

3.12.3 EMDR

Both psychotherapists specialising in trauma are practitioners in Eye Movement Desensitisation and Reprocessing, EMDR, a modality devised by Francine Shapiro (2001) that involves processing the traumatic events while orienting to present safety. It is a NICE-approved treatment for PTSD (NCCMH, 2005). EMDR may not mean talking directly about the trauma to the therapist, but it does involve visualising the worst of the traumatic events while undergoing bilateral stimulation. Such bilateral stimulation may include moving the eyes from left to right, listening to sound alternating in right and left ears, or tapping on right and left knees, or a combination.

3.12.4 Narrative Exposure Therapy

NET is a therapy based on trauma-focused CBT where patients re-live the traumatic events, while orienting to present safety, and thereby revise faulty cognitions (Schauer et al., 2011). Its distinctive feature is that it begins with the patient laying down a piece of string representing a timeline of his or her life, together with stones to symbolise negative events and flowers the positive events. The therapist writes an account of the narrative after each session which may later be used to publicise human rights violations. It was designed particularly for use in conflict situations, but in Lewisham we have found it useful for patients who find the timeline activity helpful, both in a practical and a symbolic sense.

3.13 Method of Data Collection

1. Interview procedure with participants, including researchers

Clinical rooms booked for interviews
Confirm with researchers the date and time
2. Group meetings with researchers

The training session with researchers and three post-interview feedback meetings with them were all recorded and transcribed by me. An analysis meeting on March 9, 2018 with all six researchers was recorded and transcribed by me. These meetings had a clinical aim in that they were intended to ensure patients’ safety and wellbeing, both for participants and researchers. They also had a research function similar to that of focus groups, in providing complex data from a range of participants, while empowering them to speak out about their shared experiences.

3. Participant observation

I kept a reflective log with handwritten notes on the main events, some of the conversations with staff and participants, and my experience of the research process.

3.14 Data Analysis Strategy

Transcription method.

A clean verbatim transcription of the interviews and group meetings included non-grammatical and incorrect English to reflect fully the language of non-English speakers. Non-verbal sounds were not transcribed, except laughing. The transcripts included pauses, repetitions, and indeterminate noises like ‘mm’ at the beginning of speech. The ‘ems’ and ‘uhs’ in the middle of sentences were not included. Intonation markings were not included. The Jefferson transcription system was not appropriate for the research aim which was to find out about
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patient views and subjective experiences (see Appendix P, p.180 for Transcript Notation Key).

There were three data sets for analysis:

1. **Audio-recordings of participant interviews.** Clean verbatim transcripts were done of 24 interviews, 15 by a professional transcriber and nine by me (see Appendix K for an example of a transcript). The audio recorder was only switched on after the interviewees had given their consent and this meant that the initial discussion was not recorded. All interviewees did agree to the recording. One month after completion of the interviews, I met with the researchers to agree themes for a thematic analysis.

2. **Audio-recordings of meetings with researchers.** Feedback meetings were held with service user researchers after the interview sessions and these were recorded and transcribed verbatim by me. As mentioned above, an analysis meeting was then held with the researchers.
   Data from the analysis meeting had a dual purpose. In the first place, researchers identified important themes from the interview transcripts, some of which they had given themselves. The second purpose of the meeting was to explore their experiences of the research itself. I then transcribed the recording of the meeting and all other meetings I had recorded with the researchers.

3. **Reflective log.** This contained handwritten entries and field notes on my experience as a psychotherapist and researcher during the research process. I read through the log twice and highlighted entries I felt were most relevant to the research question from my perspective as a psychodynamic psychotherapist, using psychoanalytic theory to analyse salient aspects of the research process. I am defining psychoanalytic theory here to mean an understanding of the human mind and behaviour following Freud and later psychoanalytic writers who emphasise unconscious mental processes. There was a particular emphasis on the role of attachment.
3.15 Validation of Themes

The help of academic colleagues was enlisted for the purpose of validation of themes at two levels. The first was a seminar group of 12 colleagues including senior academics and doctoral students, who studied a transcript of the research analysis meeting to validate the themes selected for analysis, both for patients’ views of psychotherapy and for their participation in the research. The seminar group also discussed psychoanalytic concepts which might be relevant to a fuller understanding of the CPTSD diagnosis and the provision of psychotherapy.

The second validation check was done by a psychoanalytic psychotherapist colleague, who is also a researcher at the University of Exeter. She read transcripts of four interviews with participants, and the researcher analysis meeting. She had no personal investment in the study. She then commented on those themes that were most relevant for the research question. These were in keeping with the themes highlighted in the findings below.
4. Analysis

4.1 Overview

This chapter presents the analysis of the three datasets which resulted from the research: transcriptions of individual interviews, transcriptions of group meetings with researchers, and the reflective log kept by me as a participant observation. I begin with a summary of the analysis strategy used for each dataset.

4.1.1 Analysis of interviews

The first section explores the themes identified as significant by the six patient researchers after they had done 24 interviews with each other and other patients. The researchers were sent transcripts of all the interviews they had carried out, as well as transcripts of the interviews they had given themselves (see Appendix K for sample transcript R2 interview with Q.) I had listened to all the interviews and read all the transcripts. Four weeks after the last interviews, I organized an analysis meeting with the six patient researchers on March 9, 2018, at which the themes were identified and discussed. I asked three questions to structure the discussion:

- What were the most important points people made about their treatment?
- What were the points most often mentioned?
- How did you feel about doing the research?

The first two questions formed the basis for the interview findings and the third question was the basis for the research process findings. I also used data from the analysis meeting itself if the researchers were giving their views on treatment. Some of them were more able to give their views freely and expansively in the group, as may be seen in a focus group (Smithson, 2008). They had been emphatic during the training that their views on treatment should be represented and this seemed to ensure the most accurate and comprehensive reflection of their views.

4.1.2 Thematic analysis for interviews

The procedure was as follows: I audio-recorded the analysis meeting and transcribed it, then searched manually and used NVivo to identify and
organise the themes selected in that meeting in response to the first two questions. These were about the most important points participants had made about treatment and the most frequently mentioned points. For example, the researchers selected the theme “trust” as one of the most important themes from the interviews and I then searched all the interviews for opinions on trust, and coded relevant data extracts, including words with similar meanings (See Appendix N). Details of coding prevalence with illustrative quotations are given below in Table 9. The main criterion was relevance to the research question: patient views on psychotherapy for CPTSD. Themes were further refined by me into a matrix with cross-cutting themes identified by the researchers, seen in Table 10.

4.1.3 Analysis of research process

The second section analyses the research process itself from the perspective of the patient researchers. This was based on audio recordings made of training sessions, the feedback meetings following interviews and the analysis meeting on March 9 (See Appendix L for Transcript of the analysis meeting Part 1). The meetings totalled about 6 hours and 44 minutes which I transcribed. In the analysis meeting the researchers discussed their responses to the question: ‘How did you feel about doing the research?’ I then coded extracts according to the themes they selected, including not only the exact words, but words with similar meanings. I then searched through all the meeting transcripts for relevant extracts. Findings are described in more detail below.

4.1.4 Analysis of Participant observation

The third section is drawn from the reflective log I kept during the research process. I searched through it for notes and events relevant to patients’ views of treatment, my experience as a clinician researcher, and to a psychoanalytic understanding of attachment and object relations theory. The participant observation as implemented here involved exploring my own emotions and behaviour to provide clues to what may be going on for others, as well as observing others. Therefore as well as the application of psychoanalytic thinking, it includes reflexivity in the sense used in social science: how my presence affected the analysis.
4.2 Analysis of Interviews

*Patient views on psychotherapy for Complex PTSD.*

The new ICD-11 diagnosis says that the stressors associated with Complex PTSD are “the result of human mistreatment” (WHO, 2012, p. 205), rather than an accident or an act of nature. This aetiological factor was singled out as fundamental by the patient researchers in the analysis meeting during exploration of the most important themes for treatment identified by the 24 interviewees. Researcher 2 said that “…it’s all about someone doing something to someone and then maybe that’s the way out. It’s through getting back in through others…” As human mistreatment had caused the problems of Complex PTSD, so recovery needed to be based on rebuilding relationships with others. Three themes identified by the researchers came under this broad heading, beginning with the relationship with the therapist, and including the relationships with others in group therapy for patients who had experienced this, as well as a broader social network.

The researchers also selected as important a further three themes: time, trust/confidence, and anger. Rebuilding trust and confidence in others, as well as oneself, was crucial to recovery. Time referred to the length of time in therapy, as well as the passage of time. The role of anger and irritability as symptoms of complex PTSD which prevented recovery through making relationships problematic was the third theme, and it was especially relevant to wider relationships in the community.

An initial thematic table (Table 9 below) was developed showing these six codes as separate and unrelated themes. However, it was clear that the latter three themes of trust, anger and time were being applied to describe the first three themes: relationships with the therapist, the group and the wider community. I felt this was significant because it reflected some of the different types of therapy on offer, as well as the peer support groups we had organised. Therefore, it seemed more meaningful to refine the analysis according to these cross-cutting themes, rather than to list them separately, and this is illustrated in Table 10. The narrative analysis which follows uses this conceptualisation.

The transcripts of interviews and the analysis meeting were coded manually by me into nodes created in NVivo, according to these themes (See Appendix N). Table 9 below shows the themes selected for coding, with the
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number of people out of the 24 interviewed who mentioned them. The themes were then refined into cross-cutting themes, analysed in a matrix depicted in Table 10.

Table 9: Themes selected by researchers and number of interviewees who mentioned them.

<table>
<thead>
<tr>
<th>Themes</th>
<th>No. of patients</th>
<th>Illustrative quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with therapist</td>
<td>14</td>
<td>I worked with [the therapist] for a year and probably for the first 5 months it felt really dangerous to be in a relationship with her.</td>
</tr>
<tr>
<td>Relationship with group</td>
<td>15</td>
<td>Once I felt more comfortable &amp; confident within the group, the group was definitely far better than talking to a single person…</td>
</tr>
<tr>
<td>Relationship with community</td>
<td>24</td>
<td>I can socialise more now without feeling panicky or thinking that I am going to be attacked or something.</td>
</tr>
<tr>
<td>Trust</td>
<td>9</td>
<td>We face problem to trust in people. When someone trust you…he can open his mind and start to tell you the things he’s facing…</td>
</tr>
<tr>
<td>Time</td>
<td>8</td>
<td>It’s too much to ask, we are gonna get you ready in one year after 35 years of craziness…</td>
</tr>
<tr>
<td>Anger</td>
<td>5</td>
<td>In the beginning of the group therapy, I had so much rage in me, I could have beaten a baby with a cricket bat to death.</td>
</tr>
</tbody>
</table>

Table 10: Interface between cross-cutting themes and rebuilding relationships

<table>
<thead>
<tr>
<th>Themes</th>
<th>Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Relationship with therapist</td>
</tr>
<tr>
<td>Time</td>
<td>Relationship with therapist</td>
</tr>
<tr>
<td>Anger</td>
<td></td>
</tr>
</tbody>
</table>
4.2.1 Relationship with Therapist

*Trust & relationship with therapist.*

Establishing trust in the relationship with the therapist was identified as the most crucial factor in recovery for a number of patients. This was because it enabled people to talk about their trauma which was experienced as healing: a ‘release’ and a ‘relief’. Subsequently, it was also the foundation for rebuilding all other relationships because suspicion and mistrust of others had been a near universal symptom of those interviewed. This is not surprising given that Complex PTSD arises from human mistreatment.

Patient Q, who had been persecuted in Uganda for being homosexual, described the relationship as ‘like the roots’, because the therapist was the first person she had been able to talk to openly, and once she had done so, she did not feel so scared of other people. She said:

> I was not trust anybody in the world, I tell the truth, and I think everybody who gonna be close to me was gonna kill me…If I didn’t tell her [the therapist], I couldn't get more improvement…(Transcript interview with Q, p.3, lines 5-6).

> My life has changed a lot because now I have people close to me…I started to love people, to trust people because before I was not trust anyone (Transcript interview with Q p.4, lines 12-14).

Researcher 7, who was imprisoned in Congo for political activities, agreed with the significance of forming trust in the relationship with the therapist:

> If someone come for therapy, the therapist have to help people because we face problem to trust in people. They have to work on it and give us, as a trauma people, the trust. When someone trusts you, he can open his mind and start to tell you the things he’s facing…” (Transcript interview with R7, p.3, lines 12-16).

The qualities and expertise of the therapist which patients mentioned as furthering trust included: empathy and understanding, patience, capacity to contain extreme emotions, professional expertise, and vocational commitment described as “she don’t do it just because of the pay”. As one patient said:
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I think it is having the knowledge that someone is a professional and that you can trust their advice, because I think when you have got no trust for anyone, you need someone that makes sense (Transcript with O, p.10, lines 2-4).

Enabling patients to confront their trauma (this was done through talking therapy including EMDR) was seen as vital for recovery by most people, including some asylum seekers who had not reached a safe and stable situation:

I was keeping everything to myself so that was like another torture, like I was feeling very down and also felt [like] committing suicide at the time, but after talking to someone and letting it out, I felt better because I felt there was someone to listen to me and also help me. (Transcript interview with E, p.2, lines 8-11.

Some patients whose experiences were at the extremes of human suffering were clear about the benefits of talking therapy:

Would you want to remember those horrible things you have been through? No, but you are trying sometimes to move forward, and it is like this thing is still there. It, like, it have a grip on you, holding you back from doing what you want to do, but [the therapist] offered to listen so you can overcome it (Transcript interview with G, p.2, lines 23-25).

A refugee from Africa whose teenage son was murdered said that “…if you don’t bring it out and you don’t talk, then it is stuck inside there and it is not very helpful at all…by coming and talking about it, yes, I did find relief myself, yes” (Transcript interview with N, p.6, lines 41-44). A number of patients felt that putting words to their trauma enabled them to feel more in control of their lives and more confident about themselves. A woman who was trafficked to the UK from Vietnam said: “…when I started to talk a bit, I can control myself and manage my emotions and my life, so I can feel a bit better” (Transcript interview with B, p.2, lines 12-13).

A number of patients who were refugees talked about how some of their early relationships in the UK had also been traumatic. Some had experienced
Further sexual exploitation, and some had undergone hostile treatment in Home Office procedures, including detention. There were some experiences of racism. The borough in which the service is located, Lewisham, has a number of Sri Lankan asylum seekers, and one of them commented:

*Because of the problems I have faced in my country and also … the UK, it was not that great memories, so whenever I saw the police or someone in the Home Office, I feel really scared. Then after talking to a therapist … they made me realise that … they are trying to help you, so they are not treating you like others … there are people here to help us, they are not like the ones in my country*” (Transcript interview with J, p.2, lines 38-43).

There was a feeling that the therapist was well disposed towards patients, including immigrants, which had not always been their experience in the UK.

**Time & relationship with therapist.**

Given that most patients with symptoms of Complex PTSD had experienced trauma over a long period of time, it also took time to rebuild relationships, beginning with the therapy relationship. Some patients felt the time allocated for therapy was not sufficient. One patient described it cogently: “…it’s too much to ask, we are gonna get you ready in one year after 35 years of craziness, I don’t think it balances out” (Transcript interview with P, p. 7, lines 48-49). Patient A, who had experienced childhood abuse, expressed it vividly: “I worked with [the therapist] for a year and probably for the first five months it felt really dangerous to be in a relationship with her…” (Transcript interview with A, p.2, line 45 & p.3, line 1).

A Syrian refugee said:

*Let me tell you from the beginning I would find difficulty in speaking about certain things, and at the end it was just normal to speak with [the therapist] about everything just really and that made me comfortable of course and made me not like before, and may I tell you I wanted [the therapist] to prolong the session more than she has done.* (Transcript interview with H, p.4, line 37-40).
Patients in individual therapy also found the end of therapy painful, particularly as the service put limits on their treatment, as normally happens in the NHS. Patient P was clear about this:

*I was having treatment for a whole year, but the fact that we had to sort everything out within a period of time, a deadline, I think it adds a bit of pressure, that this has to be sorted, this has to be finished, and I don’t think that’s quite right* (Transcript interview with P, p.5, lines 4-6).

He went on to suggest a follow-up session should be given by his therapist to monitor his situation. Patient G was even more graphic: “It is more than this that you put on the paper, it is our life, our life is robbed, it has [been] robbed from us and we need it back, so we need more help” (Transcript interview with G, p.7, lines 23-25).

Patients like G, who had experienced childhood abuse, were particularly critical about the limits on their treatment. Some felt that the longer the duration of trauma, the longer treatment may take. However, other research indicates that this is a complex issue where early problems with attachment are a major factor in later emotional disturbance, as well as the prolonged duration of trauma. Most such patients were offered group therapy lasting at least a year and their views are described below.

### 4.2.2 Relationships in group

**Trust & relationships in group.**

Establishing trust with others in group therapy was an important factor in recovery for a number of patients because it was a prerequisite for sharing experiences, which reduced shame, and feelings of being alone. A number of people talked about how they had felt anxious or ashamed on starting the group and had concerns about confidentiality and what others would think of them:

*You are gonna think about trust, confidentiality you know, yeah, so I’d say for the first couple of sessions it was really hard, but then afterwards I engaged my mind, thinking: I’m here because I want to get help so unless I participate and put something in, I’m not gonna get anything out. So I just opened up, talked about it.* (Transcript with D, p.1, lines 46-49).
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Another group member said:

*At first I was embarrassed because … I wanted to talk but in order to talk I had to talk in the group where I was telling my story to others. Obviously they’re going to tell their stories to me, but from my perspective I did feel a bit embarrassed them knowing about all the awful things that I’d gone through even though you know, I didn’t say, I said a lot but I didn’t say everything, and umm, but after a while it was OK because there was a sort of bonding…a sort of relief that, OK, it's not only you, there are others.* (Transcript interview with R1, p.2, lines 10-16).

There was a general fear of feeling exposed or judged in group, and when this was overcome, the sharing of experience and hearing the views of others was a crucial factor in recovery.

*Once I felt more comfortable and confident within the group, the group was definitely far better than talking to a single person cos you’re hearing other people’s experiences and that was great ‘cos then you knew it wasn’t just you…what was very important to me was that they listened to me too…I really did enjoy in a sense being able to talk to people that understood.* (Transcript interview with R3, p. 2, lines 4-12)

Some patients were more specific about the role of shame:

*Every time you talk to trauma, some kind of shamefulness comes, because sexual abuse is quite complicated,,and I think [it’s] maybe quite common [for] people to feel, although it is not our fault, feel like a kind of guilt feeling, so I think to share the shame…*(Transcript interview with Patient L, p.2, lines 15-18).

As well as mitigating shame, groupwork helped with building confidence: *My trauma may differ from your trauma, but we are going the same circle…so being with a group, it build my confidence, it gave me back my mojo and as I said, I made friends that I think I would never have met in my life* (Transcript interview with G, p.4, lines 9-12).
One of the groups offered was only for Sri Lankan Tamil men, who were mostly asylum seekers, and this was endorsed as promoting trust by several patients: “

[The therapist] organised a group which has got a lot of Tamil people in it, so it helped us and then it made us realise that, OK, I am not being alone like some other people, it is like family and I have got a lot of friends from the group, so I really like that group (Transcript interview with K, p.1, lines 47-49).

Time and relationships in group.

Eight patients mentioned the importance of time for recovery in psychotherapy, and those who took part in groups were particularly vocal about it not being long enough. Several mentioned that the traumatic events they had experienced in childhood, sexual abuse, had gone on for some years, and led to symptoms which had continued much of their lives. Patient D. said:

The therapy has really helped, but I need more because I am just open, you know when you get that blast and you see that mushroom cloud, I am like the mushroom cloud it hasn’t dissipated yet …this has opened up a lot of things and I won’t obviously go into depth, but my trauma happened when I was from the age of 5, and I’d say still ongoing, so to not haven’t spoken about that at all until the age I am now, I am in my fifties now (Transcript interview with D, p.2, lines 45-46 & p.3, lines 1-3).

Another patient from the same group said:

The one year therapy has finished … And if I should appeal to the NHS, I would ask them to … give us more time… I am suffering from this thing over 20 odd years, and … sometime when I go to sleep I wish I would never wake up to see another day. So I would appeal to them just to give us a little more time for us to get well (Transcript interview with G, p.2, lines 31-36).

Patients also talked about the ending of therapy being very difficult for them. Researcher 6 said:
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I don’t know if that’s normal after having that relationship, whether it’s one-to-one or in a group. But then not having it any more, that was quite a shock, I think we all, umm, well, I can only say for myself, the closer the date came to it all ending, the lower I went (Transcript interview with A, p.7, lines 40-43).

Another woman from the same group had found the same: “For myself, I remember when the group finished, and I was at home and about the third week, it almost felt like I was on a desert island, seriously” (Transcript researcher analysis meeting Pt1, p.9, lines 32-33).

Another researcher was highly critical of the lack of follow-up support:

When the therapy stops, poof, that’s it! And it’s my biggest bugbear with it because it’s just like, don’t worry, if you start feeling bad again, go to your GP and they’ll do a referral. Some people, it’s taken them years for them to go to their GP…they’re bringing out this complex trauma, but don’t just do it as therapy in a room or a one-to-one, expand people’s opportunity to help themselves a bit more. I feel very, very strongly about that. (Transcript analysis meeting Pt.1, p.8, lines 29-35)

4.2.3 Relationships in the community

While the research question was directed at exploring patient views on psychotherapy for Complex PTSD, there was also an opportunity for patients to comment on other treatment available at the service under study, as well as activities they found helpful in the community. The service offered ongoing peer support groups, as well as one-off yoga and creative writing groups. It should also be mentioned here that the ISTSS Expert Guidelines for Complex PTSD (M. Cloitre et al., 2012) specifically prescribe community re-integration as the final phase of a three-phase approach. This need not be beyond the scope of a psychotherapy service. The semi-structured interviews included a question specifically about relationships with other people: “What about your relationships with other people- how would you describe them?” All 24 interviewees answered this question, and service user researchers then also identified it as one of the most important themes of the research.
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*Trust and relationships in the community.*

Eight people talked about how they felt scared and suspicious, even “paranoid” about other people in general in the community. This was the case whether they had been subjected to political violence in their own country, childhood abuse by family members, or other trauma. One of the Sri Lankan asylum seekers described it thus:

*When I first came into this country, everyone go out for walk, I was being alone at home and I scared to go out to meet other people or to talk to some strangers. But because of the gardening group, I have got some friends and now I am not being scared to go out, so that was really good* (Transcript interview with K. p.1, lines 11-14).

Patients who had been subjected to life-threatening physical assaults had obvious difficulties with trust such as Q: “Before I don’t trust people and I feel I hate everybody. I’m so sorry. But now I started to be close to people, people they show me they are all good, not all bad, but some good” (Transcript interview with Q, p.1, lines 14-16). Patient P described rebuilding his social network: “I can socialise more now without feeling panicky or thinking that I am going to be attacked or something” (Transcript interview with P, p.4, lines 10-11).

*Time and relationships in the community.*

Time was again an important theme for rebuilding wider relationships, based on initial gains in trust and confidence in group and/or individual psychotherapy. A 71-year-old man who had been maltreated as an infant, then tortured by a military government, described it like this:

*I still working to be better, but I think it needs to have more time, and the more time giving the group, with the art, the writing group, because in them we are a big family, we know each other, we know the problem we have brought before. And that is good for me* (Transcript interview with R5, p.1, lines 17-20).
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Breaking down social isolation was an important result of attending therapy for those who were in a group, and this took time:

*Before that I was a bit hesitant to mingle with the people, now I am very good in mingling with the people. During the therapy someone will accompany me to come to the treatment and getting back, but now I am ok, I can travel on my own, I can look after me very well, so those are the changes that have happened.* (Transcript interview with K, p.2, lines 26-29).

One woman described how she found it hard to adapt to people viewing her positively because she was so used to thinking of herself as repulsive: “When people want to know me, the new people in my life, I genuinely really surprised. What he or she saw in me? Maybe they have a completely different idea of me, but they really don’t know me” (Transcript interview with L, p.5, lines 14-16).

**Anger and relationships in the community.**

Anger and irritability with other people was an obstacle to recovery which was mentioned by six people, particularly in the context of relationships with others in the broader community and their social network. Sometimes psychotherapy was not enough to help process the stored-up rage:

*I remember in the beginning of the group therapy, I had so much rage in me, I could have beaten a baby with a cricket bat to death, that sort of rage. Not that I’d ever do it, but you get my meaning, and I never got the chance to get rid of the rage. I would have liked to have a sledge hammer that I could handle and demolish half of this building just to get the rage out, you know* (Transcript analysis meeting Pt.1, p.8, lines 42-46).

One man described how even a bus journey had been problematic in the past:

*Before I am very aggressive, yes, because I felt ill, because I am no good, but now I feel very friendly…But not before, before is somebody look very often on the bus, in the street, I feel not very friendly with the people. But now I think for example last time I was coming in the bus, the*
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47, and I sit and one of the man look at me like this, you know, very angry or something. I say, don’t worry, brother, we are the same…he say: ‘Oooh, thank you.’ That means, maybe he has the same problem I had. (Transcript interview with R5, p. 1, lines 29-35)

Two people described their feelings as irritation rather than anger, such as Researcher 3:

I find that I don’t have very much tolerance with other people, I get very irritated very quickly and basically lose my rag quite often, that’s, umm, something I’m not happy about, still needs work. [It’s] better, much better than before I had the therapy, I must admit, learning to control it a lot better than I did before. (Transcript interview with R3, p.1, lines 7-20)

The factor which two people identified as enabling them to control anger was an increase in their own confidence:

I think now I’m able to set down more healthy boundaries and I’m sort of more able to assert my needs, umm, which has helped me with my relationships with other people (Transcript interview with R2, p.1, lines 7-10). I feel like now I’m putting the anger and blame where it’s supposed to be put so (laughs) how are my feelings towards other people? Well, maybe with some people it’s more negative than others? But I think that’s just part of the process, part of the healing and getting better. In terms of friendships I think that’s improved because I’m now able to speak my mind, my opinions, lay down my boundaries, say no (Transcript interview with R2, p.1,lines 51-55).

Researcher 3 agreed: “I have more confidence than I had before. To be able to walk away, rather than stand and argue, you know, I’m off, I feel more confident to do that now” (Transcript interview with R3, p.2, lines 38-40).

An analysis of the interviews reaffirms the importance of rebuilding relationships in the wider community as essential for mental health. As Researcher 2 put it: “it’s more about being a part of something and that’s more important for some people” (Transcript researcher analysis meeting Pt 1, p.11,
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lines 46-47). Social inclusion was vital for his recovery according to Researcher 5:

… ‘If I participate in different events or therapy garden or writing group, all this, I feel great, yes. If I don’t have these things, I feel out the community…these programmes, our group, writing group, different thing yes? I feel inside society (Transcript interview with R5, p.1, lines 6-11). The significance of social inclusion for patients with Complex PTSD is further elaborated below in the next analysis chapter on the research process.

4.3 Analysis of Research Process

At the analysis meeting attended by all the patient researchers, I asked how they had felt about doing the research. The purpose of this question was twofold: firstly, to gauge whether any emotional disturbance had been experienced that needed to be addressed; and secondly, to explore whether one of the original aims of choosing a participatory methodology, the promotion of recovery and social inclusion, had been achieved. I searched the transcripts of all meetings with service user researchers using NVivo to code manually any mentions of the theme: “Experiences of the research”. There were 47 extracts in total and all 6 researchers made more than one contribution. Twenty-five of the extracts came from the analysis meeting on March 9 at which this theme was specifically considered. From this overarching theme, 3 sub-themes were identified: anxiety about doing the research, identification with the interviewees, and an increase in feelings of self-worth and confidence as a result of doing the research. This last was an unexpected and positive outcome. The researchers felt that doing the research signified that they were further on the road to recovery than those they were interviewing because they had been given responsibility.
Table 11: Themes identified by researchers on their experience of doing the research.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Number of mentions</th>
<th>Illustrative quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>7</td>
<td>I’m always afraid when I don’t know the situation well</td>
</tr>
<tr>
<td>Identification with interviewees</td>
<td>10</td>
<td>I realise the thing I am facing myself, there are many people who are facing the same</td>
</tr>
<tr>
<td>Increased confidence</td>
<td>15</td>
<td>It kind of gave me confidence back that, you know, there is something I can do.</td>
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<tr>
<td></td>
<td></td>
<td>It sort of makes me feel a sort of leadership role</td>
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</tbody>
</table>

4.3.1 Anxiety about doing the research

All the researchers felt anxious about doing the interviews to some degree. Researcher 2 said:

*I was really dreading, I was really nervous about coming and doing it and I was rehearsing and rehearsing. I rehearsed to the point of, like, I’m sounding robotic almost, I’m sitting there like it’s just automatic, like I’m reading some sort of script, I’m in a play or something...*(Transcript researcher feedback Dec.28, p.3, lines 32-36).

Some of the anxiety was about doing something new, as Researcher 1 said: “I’m always afraid when I don’t know the situation well.” There were also concerns about keeping boundaries in the interviews so that patients did not start to tell their story, but rather were focussed on how they felt about their psychotherapy or other treatment. Researcher 1 described her sense of near-panic: “At first I was very nervous and scared and I remember the last day, I was all over the place, wasn’t I? And I thought, Jesus, I can’t do this today. You know, I couldn’t not do it” *(Transcript analysis meeting Pt 2, p.9, lines 37-39).* There was also a desire to help the clinician: “I wanted to do a good job, a
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good enough job for you and not embarrass myself” (Transcript analysis meeting Pt.2, p. 9, lines 44-45).

4.3.2 Identification with interviewees

All the researchers talked about how they had identified with their interviewees and felt empathy for them. Researcher 7, who was allocated an interviewee from his own country, said: “I can say it’s make me remember because someone coming from the same country as me…I realise the thing I was facing myself, there are many people who are facing the same” (Transcript analysis meeting Pt.1,p.3, lines 27-31). This decreased their sense of social isolation.

Some researchers struggled with taking on the new role:

In a way, I felt, who the hell am I, asking people these questions, you know, I’m no better than them, you know…I said it several times that I was a service user and so forth and so forth. I didn’t want them to think: ‘Oh, someone’s judging me asking me these questions (Transcript analysis meeting Pt.1, p.3, lines 39-45).

Two researchers struggled because they empathised so much that they wanted to hug their interviewee. Researcher 6 described her experience:

I found the first one quite difficult…I really did want to give her a hug and I can’t remember if I did or not, I don’t think I did, but there was just a connection and I clicked with what her story was about, and I just felt energised by her because she had done so much, I thought it was really, yeah, amazing. (Transcript analysis meeting Pt.2, p. 1, lines 19-24).

A number of the researchers felt that they could be seen as a helpful role model for their interviewees. Researcher 2 saw it like this:

When they see people like themselves who are on the other side and they’re giving the interview and they feel they’ve come through it, and they feel like there’s some hope there, that you know, they’ve gone through what they’ve gone through…and now they’re sitting there, taking on the role of, not therapist, but an interviewer, but almost like a therapist…” (Transcript researcher feedback Jan.30, Pt.1, p.1, lines 41-46).
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Researcher 1 added to this: “It sort of makes me feel a sort of leadership role…in the sense that it’s like I’m helping them to…achieve something…Like a facilitator, you’re giving them a stage to say something” (Transcript researcher feedback Jan.30 Pt.1, p.1, lines 35-36 & p.2, line 5). This experience of facilitating others to have their views heard resulted in the researchers’ valuing themselves more highly and recovering some of their self-confidence.

4.3.3 Increased self-worth & confidence

One of the purposes of asking former service users to carry out the research interviews was to enable them to connect socially with others through the research project, and thereby promote their emotional health (see Section 1.7.3, p.19). The project did enable them to connect socially with others, but it was a very specific aspect of the connection which they identified as promoting recovery. This aspect was that they felt they had been given responsibility to help others who had been service users, such as they had once been themselves, and were therefore being recognized as having gone some way towards recovery. Researcher 2 explained it:

Being the interviewer, like, puts us in a position of responsibility which probably helps us as people as well because it makes us feel, not completely recovered, but we’ve gone some way towards recovery and, um, maybe subconsciously or in a placebo way, I’m not sure, yeah, it takes us a step further in terms of our recovery to see how far we’ve come (Transcript analysis meeting Pt.1, p.3, lines 46-48).

Researcher 6, who carried out seven interviews, said:

My experience of it, yeah, kind of similar to what [Researcher 2] said about the position of responsibility and even though I thought I wasn’t as far ahead as I thought I was, sitting in the room and being there, showing up, doing it, kind of showed me: actually, yeah, we can do stuff instead of staying in our own little bubble, so yeah, it was quite nice that (Transcript analysis meeting Pt.1,p.5, lines 6-10).

Two researchers said that they had recovered skills that they had once had. Researcher 1 said: “I think I saw a part of myself that I used to know many
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years ago” (Transcript analysis meeting Pt.2, p.9, lines 34-35). Researcher 2 was more specific:

…I thought I was utter rubbish at everything…But when I was doing those interviews, because I used to interview people on a daily basis, several of them a day, for years and years over a different issue… I actually enjoyed it. Because I thought: I’m rusty, fair enough, but it kind of gave me confidence back, that you know, there is something I can do (Transcript analysis meeting Pt.2, p.10, lines 38-44).

Researcher 3 said that participating in the research had in itself been therapeutic, not only because of her increased confidence, but also because she had changed her mind about the therapy she had herself experienced. She now felt “far more positive” about therapy because she actually realised “what the point of it was” (Transcript analysis meeting, p.10, line 22) after interviewing 3 former patients and taking part in training and feedback sessions.

This analysis concludes that all six researchers felt that taking part in the research had been a therapeutic process in itself and benefitted their mental health in the ways described above. Given that one of the additional symptoms of the new ICD-11 diagnosis is “persistent beliefs about oneself as diminished, defeated or worthless” (WHO, 2018), this is an important finding.

4.4 Participant Observation by Psychotherapist Researcher

Analysis strategy for participant observation

This section is based on a reflective log, referenced as Log, which I kept during the research process from June 27, 2017 to March 9, 2018. The analysis is based on a psychoanalytic understanding of participation observation because psychoanalysis provides a useful theoretical framework to understand the research findings. Elaborating the findings in terms of concepts such as attachment, transference, countertransference, identification and splitting may make a contribution to answering the research question. As the observation includes my own thoughts and feelings, it also allows my role and perspective to be open to scrutiny.
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Reflexivity and analysis: how did my role affect the findings

I have explained that all those contacted for research purposes had been patients in the service I run, either my own patients, or those of staff managed by me. Although the interviews were done by former patients themselves, all those interviewed were aware that I would hear the recordings afterwards. A frequent dynamic in therapy relationships is unequal power: at an overt level, someone is seeking help from another. This may also be conceptualised as replicating the attachment relationship, and psychotherapy has been described in this way by many writers (J. Holmes & Slade, 2018b). There may be also class, gender and race dynamics in the relationship, some of which may be unconscious. I have not covered these latter aspects in this study.

While I said above that a frequent dynamic in therapy relationships is that a patient is seeking help from a therapist, in the research process for this study that dynamic was reversed in that a therapist was seeking help from former patients. I was aware that at one level I was asking the participants to do something for me, as the study constitutes a thesis for a professional doctorate qualification.

I was also aware that my own attachment system as well as that of former patients, could be activated by the research process. By this I mean that although I was in a professional caring role, I had personal feelings towards former patients, “affectional bonds” in Bowlby’s (1979) words, which predisposed me towards maternal enactment. In a psychoanalytic sense, this included countertransference, which I understand to be an initially unconscious co-creation between patient and therapist, following Ogden (1994).

Themes in participant observation

The strategy I used to identify findings in the log was to search through it for events and notes relevant to both aspects of the power dynamic, as well as to themes selected by researchers in the interviews and the research process. Psychoanalytic thinking using an attachment and object relations framework was applied. The themes identified as relevant, which will be detailed below, were:

- Activation of the attachment system in research
- Attachment and maternal transference
- Attachment: help-seeking and help-giving
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Researchers take control in methods and analysis
Gratitude and the internal world
Attachment and ideas about self
Attachment and the wider world

4.4.1 Activating the attachment system in research

As a psychotherapist, I was excited about the possibility of using the research process to promote recovery by involving patients as fellow researchers. I have explained above how I was influenced by writers and practitioners in the related fields of international development and liberation psychology (see Section 1.7.1, p.20 and 1.7.2, p.20). My notes record the first call I received after sending out 29 letters to potential researchers: “So excited! The first person called to say she was interested in being a researcher but she is 6 months pregnant, so is it worth her participating? She added that another person [Researcher 3] is also interested; they spoke about it together. (Log, 18/10/17)” The pregnancy of this first participant was a useful boost to complete the research interviews within three months, before the baby arrived. It also illustrates the activation of an attachment system where I was concerned to ensure the pregnant participant was able to take part. My notes in the Log suggest that during the research I was both viewed by participants in a maternal role and experienced myself as such. It seemed that this may have had a positive effect in facilitating the research process as will be elaborated below.

4.4.2 Attachment and maternal transference

Many analysts have compared the therapy relationship to early infantile relationships, and writers on attachment emphasise the fundamental human need for connection and healthy dependence (Holmes & Slade, 2018b). Attachment theory highlights how the external world and significant others in it have an impact on the internal world. Object relations writers tend to focus on how the therapist can take on a maternal role through unconscious mechanisms such as transference and countertransference. I explained earlier (pp.59-61) that my understanding of countertransference follows that of Ogden (1994) and Holmes (2014) where it is seen as a co-creation of both therapist and patient, or of researcher and participant. My Log notes that there were at
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least two patients who were interviewed who referred to me as their mother, one even describing me as a “life-time mother” (this was a translation from Tamil.)

Seager defines the external conditions for psychological safety as:

*To be held in mind and thought about in an empathic way by at least one other person in whom there is at least a basic level of trust (i.e. attachment) and with whom there is reasonably regular contact and the opportunity of rapid support at times of heightened need.* (Seager, 2006, p. 271)

It is significant how trust and attachment are equated here, given that rebuilding relationships through trust was identified by patients as the most important aspect of psychotherapy for Complex PTSD.

### 4.4.3 Attachment and help-seeking

It was notable how help-seeking in times of heightened need, one of the characteristics of attachment, was evident during the research process. After agreeing to do the research training, two of the researchers approached me to ask if I would provide letters about their mental health for the housing department. I noted the conversation with one of them:

**Researcher:** I have a problem with my landlord, the rent is £800 a month and if I go to college this is all I have to live on…If the Council can give me a flat, can you do a letter? I went to the CAB and they said they will help me.

**Catherine:** You know, you don’t have to do the training. I know it’s maybe like that in your country, but I’ll give you the letter anyway.

**Researcher:** No, no, no, I know you, I know what you’re like, the work we did. I know where I was then, and I know where I am now. (Log, 8/11/17)

Some professionals might see the dialogue above as an illustration of over-dependence on services. However, using the lens of attachment theory, it may have been a psychologically healthy way forward for this patient, a refugee from Africa. He disclosed in the analysis meeting with other researchers that he had gone back to university but was now having his benefits withdrawn as he...
It may be useful to explain that the team is often called on to help with practical issues such as housing or immigration, partly because of the shrinkage in public services. This seems to be a particular difficulty for patients with a background of trauma, such as domestic violence or civil war, and although this help is not our core function of psychotherapy provision, we do often respond.

4.4.4 Attachment and help-giving

As highlighted above, the power dynamic between therapist and patient was reversed in the implementation of this study where I was asking former patients for help. It may be the case that when I asked for help, this eroded role boundaries in a positive way. A number of participants openly expressed a desire to help me, as well as other people. “I wanted to do a good job for you,” said one researcher in the analysis meeting. She went on to describe how she had felt herself to be in the role of a therapist when doing interviews with participants. This may have been an identification with me and I concluded that taking on the researcher role had enabled people to rediscover and reintegrate powerful and helpful aspects of themselves which had been lost.

Psychoanalytic theory can also be useful in understanding how organisational dynamics may affect patient recovery. A number of analysts describe how defences against anxiety on the part of health staff can result in unhealthy psychological splitting where patients are helpless and only staff can be helpful. Hinshelwood’s described “a specific dynamic of helplessness” (2010, p. 215) which he discerned in the relations between staff and patients in an institution, where patients lose their healthy side and the negative attributes of staff are relocated in patients.

This may have been relevant to my experience in a team meeting when I presented the research plan to psychologist colleagues. One reaction was that I had embarked on a brave, but foolhardy, venture. A colleague said with some scepticism: “It’s risky getting patients to do research because they’re patients” (Log, 3/5/2017). One possible implication was that patients were not capable of doing the research; another was that I was exploiting them.
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However, the positive experience of the participants in fact suggests that it may have been particularly helpful for patients with the experiences of mistreatment which led to CPTSD. Often the experiences were marked by helplessness and the impossibility of escape.

4.4.5 Patients recover power

Researcher changes to methods.

In the first training session with researchers, there was evidence that the new researchers were thinking about how to re-negotiate their new role. Rather than being patients with a clinician having the decision-making power, some of the researchers wanted to change this dynamic. During a discussion on the questions to be asked of participants, one researcher asked: ‘How much can we control what happens and how much do you direct it?’ (Log, 15/11/2017). They made a major change to the methodology in that I had intended them to interview other patients outside the researcher group, but they insisted that they would also interview each other first: “What about us – don’t we get a chance to have our say? What about interviewing each other; would that be useful?” (Log, 21/11/2017).

This was beneficial to the research in that they were able to run through the questions and familiarise themselves with the audio recorder equipment with each other, before going on to interview participants they had not met before. It also gave them a chance to experience being interviewed. When it came to doing the interviews, there was often a long discussion between the researcher and the interviewee before the audio recorder was switched on. While some of this was necessary for information and signing the consent form, the discussion may have included aspects the former patients did not want me to hear. I was intrigued to know what had happened in this time period but did not feel it was ethical to include information about it in the study.

Researcher changes to analysis.

I have to acknowledge that I struggled during the research process with my desire to continue with the professional agenda I had planned. I had drawn up a list of questions for the semi-structured interviews to which the researchers made some changes. The questions included the issues which are salient for many clinicians running a trauma service with complex patients:
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- Is it always useful to confront the trauma?
- Are stabilization techniques useful on their own or as a treatment adjunct?
- Are groups better than individual therapy for patients?
- What do patients feel about EMDR?
- What do patients feel about Narrative Exposure Therapy?

However, when the patient researchers analysed the transcripts and identified important themes, these were not the themes they identified, and I had to give up my professional clinical role in favour of the researcher collaborator role specified in the methodology. The research question was answered, but not in terms of the professional agenda.

4.4.6 Trust, gratitude and the internal world

The findings from the interviews contain largely positive feedback on the psychotherapy which our team offered, and this was a surprise to me. In order to help me evaluate whether it was a result of bias on my part, I asked the researchers to comment at the analysis meeting. One of the researchers also admitted to being surprised as she herself had been critical of the treatment she received, and had said so in previous research. She said that she now felt more positive about the therapy itself after participating in the research. Another researcher felt that she and others would have been more inclined to agree to an interview if she had wanted to complain. One patient did in fact say that he had come to give negative feedback about his therapy which he felt had not been sufficiently “tailor-made” for him (Interview by R6 with S, p.4.line12).

It is useful to analyse the positive changes experienced by CPTSD patients in the light of Melanie Klein’s theories on envy and gratitude (1975). Klein theorized that an infant’s early experiences of being fed are likely to define its future relationships with other people. She uses this model to understand the relationship between therapist and patient in the consulting room. While Klein particularly focused on envy of the mother’s feeding capacity as having a negative impact on the infant’s psyche, she also described how gratitude for good feeding experiences could have a positive influence on an infant’s internal world, as well as external relationships. “The more often gratification at the breast is experienced and fully accepted, the more often enjoyment and gratitude, and accordingly the wish to return pleasure, are felt…Gratitude is closely bound up with generosity” (Klein, 1975, p.189).
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I noted how frequently participants expressed thanks to their therapist in their interviews and there was one former patient who arrived with a box of chocolates wrapped up in a red shiny parcel with a bow to be passed on to his therapist. Melanie Klein points out the significance of a good internal object which loves and protects the self and is loved and protected by the self. This, she says, “is the basis for trust in one’s own goodness” (1975, p.188). It may be that former patients continued to feel attached to their former therapist, including myself, and therefore highlighted their positive responses.

4.4.7 Trust, attachment and ideas about self

Attachment theory describes how emotional mirroring and nurturing affects how people see themselves. Herman describes how traumatic events “shatter the construction of the self that is formed and sustained in relation to others” (1992a, p. 51), and this is relevant in the context of beliefs about oneself as diminished, defeated or worthless, experienced in Complex PTSD. Symptoms may also include deep and pervasive feelings of shame, guilt or failure. The mistreatment, which led to these symptoms, had happened in situations where people had been helpless and powerless. When the researchers were asked to do the research, they experienced themselves differently, both in relation to me and the wider world.

A psychotherapist colleague added another dimension in a later discussion: “Because you trusted them to do the research, they trusted themselves to do it” (A. Johnson, personal communication 2/5/2018). This interpretation of the therapeutic dynamic illustrates the interaction of the internal and external worlds. It is well described by Hinshelwood (1994) when he talks about “the sense of a helping object” in the external world being vital for psychological wellbeing.

4.4.8 Trust, attachment and wider social connection

When recruiting participants for the research, I received an e-mail which read: “The fact that we will all be a part of the system from the inside, will provide a glimpse of how this part of the psychological therapy is run, in regards to the type of trauma you and your team deals with” (e-mail 26/10/17). This perception of being “a part of the system from the inside”, or socially included,
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proved crucial during the research process in generating self-confidence in the researchers. This was the basis for rebuilding other relationships which are part of the healthy attachment necessary for psychological wellbeing. One researcher was emphatic about this aspect: “If you've got complex trauma, more than one site of the trauma...then what you experience in therapy is not necessarily going to help with all the complexities of it. So if you have another thing outside, like you do volunteering and things like that...”(Researcher analysis meeting Pt.1,P.8, lines 23-25).

Seager also describes the need to “feel connected to other human beings socially in a way that affords a sense of belonging, identity, shared meaning and purpose. (2006, p. 271)” I noticed that patients in the research group began to relate to each other over time, bringing in information that other group members were interested in and buying tea they thought others would like.

Seager warns against the danger of overinflating the importance of the therapy relationship in terms of psychological wellbeing and says that it is the “total impact of the whole configuration of ‘object attachments’ that is critical” (2006, p. 275), in both internal and external worlds. Researcher 3 was emphatic about this too, saying: “Deal with the complex trauma, but don't just do it as a therapy in a room or a one-to-one, expand people’s opportunity to help themselves a bit more. I feel very, very strongly about that” (Researcher analysis meeting Pt 1,P.8, lines 33-35).

4.5 Summary of Findings

This chapter analysed findings from three datasets: interviews with former patients, group meetings with the researchers, and a participant observation by the psychotherapist researcher. There was collaboration between the psychotherapist and former patient researchers in deciding the themes for thematic analysis in the first two datasets. A phenomenological approach was taken. The third dataset, the participant observation, was implemented on the model of psychoanalytic infant observation where the observers use their own reflexivity as data. I understood this to include countertransference, defined as an intersubjective co-creation by myself and the participants. Psychoanalytic thinking on attachment and object relations informed the analysis of this dataset.
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While psychoanalysis often focuses on the dynamics of the internal world, attachment theory based on object relations highlights the significance of the interaction between internal and external worlds. This was central to patients’ views as they identified that rebuilding relationships based on trust (or attachment), at individual, group and community levels was essential for recovery from Complex PTSD, where psychological harm is inflicted by human mistreatment. It may be understood that there had been a repair to their Internal Working Models after the disastrous breakdown caused by torture or abuse. They particularly emphasised the significance of the relationship with the therapist and the need for sufficient time to make that relationship.

I will summarise here the implications of the study’s findings for clinical practice, methodology and theory, and these will be discussed fully in the next chapter, together with the study’s limitations, and directions for future research suggested by its results.

4.5.1 Implications of findings for methodology

A participatory approach to research where patients collaborate with a clinician can contribute to clinical recovery by increasing patient confidence and promoting a social network.

4.5.2 Implications of findings for theory

Attachment theory and object relations can help to understand the symptoms of CPTSD through locating the therapy relationship and wider social connections in the interface between internal and external worlds.

4.5.3 Implications of findings for clinical practice

The symptoms of CPTSD in terms of affect regulation, feelings of worthlessness, and interpersonal difficulties are best addressed through rebuilding relationships in psychotherapy with the therapist and group members and through rebuilding relationships in the wider community.

Patients with CPTSD feel it is helpful to talk about traumatic events within a relationship of trust

Patients with CPTSD feel it takes time to establish trust and that sufficient time needs to be allocated for therapy.
5. Discussion and Conclusions

Overview

In this chapter I will summarise the research findings, including the participant observation, and then go on to discuss how the study’s findings supported or not the existing literature on psychotherapy for CPTSD. I will mention briefly the question of differential diagnosis with regard to the overlap between CPTSD and borderline personality disorder, which has implications for clinical practice. I will also discuss difficulties and opportunities, which arose during the participatory methodology, that merit further consideration. I will review the use of a participant observation as a novel dataset. I will then conclude with limitations of the study, ideas for future research, and an evaluation of the study’s implications for theory, practice and policy.

5.1. Summary of Research Findings

The research makes a contribution to knowledge on patient views of psychotherapy for the new diagnosis of CPTSD through interviews with 24 people with the symptoms described in ICD-11. The research has particular value because the interviews were done by patients themselves, who also contributed to data analysis. The participants included a variety of adult men and women of all ages in the community, reflecting the heterogenous nature of the diagnosis. They included 15 people who grew up in non-Western cultures. All had experienced human mistreatment as described in the new diagnosis, either torture as an adult and/or abuse in childhood.

The findings were that rebuilding relationships based on trust was the most active mechanism for recovery for people with such past experiences of interpersonal violence. The relationship with the therapist was the most important, firstly because it enabled people to talk about the traumatic events, and secondly, because it enabled people to build confidence sufficiently to relate to others in the wider world.

Groups were helpful in reducing shame as well as social isolation and in facilitating the rebuilding of social connections.
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Time was identified as a significant element in psychotherapy for CPTSD. Participants in the study experienced an average of 36 sessions (range=12-74 sessions) and some described it as insufficient. Addressing anger was also a significant element in treatment for this patient group.

The participatory design of the study was effective in gathering views from patients and in ensuring that their views were definitive in the analysis of significant factors in their psychotherapy. It had an added advantage for clinical practice in that it increased self-confidence in the researchers which was helpful in the context of the CPTSD symptom of feeling worthless. It was particularly important to empower people given their previous experiences of powerlessness and helplessness.

Concepts from psychoanalytic theory applied in the participant observation provide triangulation for these findings by explaining how and why human mistreatment may have disrupted both internal and external worlds, resulting in the symptoms of CPTSD: difficulties in emotional regulation, problems in relating to others, and lack of self-worth. Psychoanalytic theory also suggested how these could be overcome through building new relationships and a new attachment system. Bowlby’s elaboration of attachment explains how early experiences with carers are the pattern for later relationships and De Zulueta (2009) explains how if these early experiences are traumatic, this may be so in later attachment relationships. Herman points out how traumatic events, such as interpersonal violence, “shatter the construction of the self that is formed and sustained in relation to others” (1992a, p. 51), and this is relevant in the context of beliefs about oneself as diminished, defeated or worthless, which are experienced in Complex PTSD. It explains why it may take some time for relationships of trust to be re-established in therapy and why trust may be seen as the most important therapeutic factor.

5.2 Findings in the Context of the Literature

The findings of this study support the literature which calls for an adaptive approach to psychotherapy for people with symptoms of CPTSD. Such an approach may include groupwork and wider social activities. The study does not affirm specifically a phase-based approach, although it is the
case that psychotherapy in the team under study generally begins with stabilising clients and helping with resources to manage emotional dysregulation. This may include techniques such as breathing and grounding, as well as visualisation such as the Safe Place. In fact, as several writers point out in the literature (Classen et al., 2017; Fallot et al., 2011), the phases of treatment do not only take place sequentially, but skills training may be revisited in a spiral approach. For instance, in the women’s group run by the team relaxation techniques are used in every session throughout the one-year therapy. However, the study results are in keeping with the evidence from the literature that people with CPTSD may not respond well to short-term trauma-focussed therapy. The participants emphasised that trust had to be built with the therapist, followed by other people, and that this takes time. Some did not feel that one year was enough.

The study provided evidence of patients’ views that talking about trauma can be healing in the context of a relationship of trust. The participants in the study were emphatic that it was like continuing the torture to repress their thoughts and feelings about the traumatic events. They were also articulate about how difficult it was to do the talking, although they felt it was imperative.

This study provided support for adapted models of treatment reviewed in the literature including womens’ groups for those with a history of abuse. One of the models described in the literature review, the Trauma Empowerment and Recovery model, TREM, (1998, p. 126) has been used in our team and received a positive response from the women in the group. The Narrative Exposure Treatment model, NET, (Schauer et al., 2011) is also used in our team and not only with refugees, but we do not complete it within 20 sessions. The other form of adapted group therapy, which some participants had experienced in the study, was a 20-session group consisting of horticultural activities and psycho-education on CPTSD for Tamil asylum seekers. This is a group based on gardening activities such as that run by the charity, Freedom from Torture, (Pointon, 2005), which we have adapted to provide treatment for Sri Lankan Tamil male asylum seekers. Patient views on this model are positive but as long as they may be threatened with deportation by the UK Home Office, psychological recovery is unlikely.
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Critics of the PTSD diagnosis often mention its power in terms of its influence on how people think and act (Summerfield, 2001). What is not given its full due by such critics is the power to access support and resources that may accompany diagnosis on a Western mental health model. This may be valuable particularly in a situation where human rights are under threat. In the UK, diagnosis can offer access to NHS services and treatment. For example, asylum seekers joining the refugee group at IPTT may access education on techniques to help with nightmares, gardening activities, social interaction and NHS documentation on their mental health which may help their case at the Home Office.

The issue of different cultural understandings of mental wellbeing as well its social and political context, is germane to this study, where 15 of the 24 participants came to the UK as adults. The psychotherapy models which were under study included social, political and cultural factors if appropriate. For instance, the women’s group includes discussion on the different roles of boys and girls and how this may affect emotional wellbeing. The refugee group may include members’ experience of government oppression and the contribution of colonialism to current ethnic conflict in Sri Lanka.

The literature review included many clinicians who called for a new approach to working with Complex PTSD because the current evidence for appropriate psychotherapy is limited, and often the treatments for core PTSD, which are offered to patients, are not being taken up or are not effective. This study of patients' views provides evidence for what might work better: that patients who have had such experiences of human mistreatment need time to rebuild relationships and that trust is the active mechanism for change in this process. While this might not be unexpected, it has not been previously been established through empirical research, and has in fact been contested in the literature (de Jongh et al., 2016).

5.3 Reflections on Methodology

5.3.1 The challenges and opportunities of a participatory approach

A review of the implementation of the participatory approach revealed both opportunities and unforeseen challenges. The first opportunity was the NHS volunteer training provided by the SLaM Volunteer Development Co-
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ordinator which included training on working with patients around issues such as confidentiality and financial probity. The training process included help with DBS approval which is often a major bureaucratic obstacle. Unfortunately, the challenge of obtaining DBS approval for asylum seekers proved insurmountable because they do not have the necessary documentation. There was an option of going to the local police station in person to be interviewed but I felt this was not an acceptable request to make of former patients who already had traumatic experiences with the authorities, albeit in another country. This meant that it was not possible to recruit asylum seekers to be researchers.

The organisation of group, rather than individual, meetings with the researchers was useful for two reasons. It meant that the previous dyadic therapy relationships, which some of them had experienced with me, were not invoked. It also encouraged the researchers to take more ownership of the research project in that together they were more able to make their voices heard. The issue that caused most stress in the training session was how to prevent former patients from going into detail about their histories, which could have been upsetting both for the interviewees and the researchers. This was addressed in the preliminary discussion before the audio recorder was switched on and can be seen in the Interview Schedule questions (Appendix M).

There were practical issues in taking a participatory approach that meant that I had to make last-minute organisational changes. Most of these arose from vicissitudes in the daily life of the researchers. For instance, on the first day of the scheduled interviews one of the researchers left a message to say she would not be able to come because of a family emergency. Another researcher did not arrive on time and when she was called, she said she had thought it was tomorrow. These scheduling problems were addressed through reallocating interviews to researchers who had arrived early and delaying the arrival of some participants. More serious participation problems included one of the researchers needing an operation on each eye in turn. The researcher who was pregnant also needed her interview schedule adapted to allow for antenatal appointments.
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When arranging the interviews there were opportunities to consider how the researcher and interviewee might interact for their mutual benefit in a matching process. For instance, I considered whether it would be useful for people from the same country to talk together or those with similar experiences. At least two researchers were excited about having interviewed participants with similar experiences and felt that it had been therapeutic for a variety of reasons. For instance, a researcher spoke to a participant from a different area of his own country and felt less isolated as a result. I did wonder whether the lengthy conversations, which often took place before the recorder was switched on, may have included such interactions. This kind of matching deserves closer consideration in any future participatory research project.

There was an underlying challenge in being a professional in collaboration with patients in terms of the power dynamic. I have said that I found it hard to give up the professional agenda that I had planned for the research. I had intended that we would focus on the issues which many clinicians are most concerned about, such as:
Is a stabilisation phase useful?
Is it helpful to talk about trauma?
Which modality do patients feel is most effective?

Managing my emotional resistance to the patients’ agenda was key to facilitating the emergence of an authentic participation. Although it was sometimes a struggle for me to revise my thinking, it was a vital part of genuine collaboration.

Academic evaluation of objectivity and potential researcher bias in the health field tends to highlight the disadvantages of a researcher studying patients they have worked with. However, one important advantage in facilitating patient participation and empowerment may be a pre-existing relationship of trust. This is affirmed by Liamputtong in her book “Researching the Vulnerable” (2007), where she identifies the establishment of trust as a crucial factor in successful research with vulnerable people.
5.3.2 Reflections on participant observation

Subjectivity and objectivity

This method had a dual function: to address concerns about objectivity by opening my subjectivity to scrutiny, and to facilitate the application of psychoanalytic thinking to the research process. I wanted to acknowledge the dataset as my personal perspective, rather than a neutral framework, to avoid it privileging my analysis at the expenses of other participants. This was particularly important in the light of the existing unequal power dynamic, given my former role as therapist to some of the participants.

To reflect first on my subjectivity, I found it productive to balance the demands of the clinician and researcher roles. While positivist conceptions of academic rigour view neutrality and objectivity as indispensable, qualitative researchers have argued that subjectivity cannot be set aside. I would also argue that emotional investment in research may be a positive influence. As a psychotherapist, I want to know what works for my patients and am ready to change the way I work, and indeed whether I work as a clinician at all, if it were found that other activities such as community action were more helpful. However, I do accept that I am not exempt from unconscious bias and that examination of my background, motivation and values was necessary to allow evaluation of the study.

While analysing the participant observation using psychoanalytic thinking, I realised how powerfully my own attachment system was activated during the research. The process provoked at times overwhelming feelings of concern for the participants which was seen from the beginning when I wanted to ensure the pregnant researcher was able to participate. Other occasions were when I permitted a participant who was involved in dangerous work to take part in the research (although it had been a criterion that researchers were not working), and when I allowed a group discussion about a researcher's financial problems to take up time in the analysis meeting.

5.4 Reviewing the Contribution of Psychoanalytic Thinking

The relevance of object relations and attachment theory to adults with experience of symptoms of Complex PTSD was borne out in the results of the
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research, as explicated in the participant observation analysis (Section 4.4. pp.93-100. There were two aspects to its relevance. The first aspect was in giving a context to the difficulties experienced by those with CPTSD, particularly the symptoms of emotional dysregulation, feelings of worthlessness, and interpersonal problems. The second aspect was in suggesting possible pathways to recovery. The title of my thesis, “Getting back in through others”, is taken from a suggestion by one of the participants, Researcher 2, which I also quoted under “Patients’ voices” (p.4). She said: It’s all about someone doing something to someone, and then maybe that’s the way out. It’s through getting back in through others, yeah, learning to rebuild again, isn’t it, yeah…”

I understood her to mean that just as the original trauma had been inflicted through human mistreatment, so the way to recovery was through rebuilding relationships with other people in a new attachment system.

I noted in the participant observation analysis (p.100) that there were at least two patients who explicitly referred to me as their mother in the interviews which brought to mind how writers on attachment emphasise the fundamental human need for connection and healthy dependence. Help-seeking behaviour which is characteristic of attachment was seen in some of the participants during the research and I interpreted this as psychologically healthy step for those who had been socially isolated and mistrustful of others. Attachment theory describes how emotional mirroring and nurturing affects how people see themselves. Herman (1992b), as well as Lemma (2004), describe how the construction of the self, which is formed and sustained in relation to others, can be shattered by trauma. This is underlined by Klein’s emphasis on the significance of having a good internal object which loves and protects the self because she sees this as ‘the basis for trust in one’s own goodness’ (1975, p.188). This would explain why patients with extreme experiences of human mistreatment feel themselves to be worthless, as well as mistrusting others. These psychoanalytic ideas affirm the study’s findings that rebuilding trust in relationships with others, beginning with the therapist, was the way forward for the participants in psychotherapy for CPTSD.

Turning now to the research process, I said earlier that in a neighbouring NHS Trust, Oxleas, a researcher network has been set up with the express
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purpose of promoting the recovery of former patients (Springham et al., 2011). In this sense, the study constituted a living demonstration of patient views on treatment for Complex PTSD. Thus the application of psychoanalytic thinking to the research process explored how former patients had made an attachment to their therapist, to others in their group and also perhaps to the hospital itself where the research was located. The researchers demonstrated how they were able to recover some of their skills and capacities, as well as feelings of self-worth, which had previously been lacking. This can be understood in terms of their becoming less helpless when put in a position of responsibility (“like a therapist”). Their taking control of the research analysis through collective discussion in the group was a powerful indication of how a wider attachment network may contribute to recovery.

The application of psychoanalytic thinking through the participant observation helped to explain the findings from the other two datasets so that the conclusions from all three datasets form a coherent narrative

5.5 Limitations of the Research

I have discussed in the reflections above some of the study’s limitations and will mention here those which were not covered. The small size of the sample, 24 people, was a limitation in that more views would have been valuable. However, the study methodology would have been difficult to implement across larger numbers. The inclusion criteria were as broad as possible to ensure a representative and realistic community sample, and this meant that varied populations groups were included. As a result of this heterogeneity, patients selected generic aspects of psychotherapy as important, rather than specific modalities, and there was no comparison between different methods of psychotherapy.

I have intentionally not included any outcome measures of patients’ mental health in the study, although it was considered. This was because it was more in keeping with the qualitative and participatory methodology to focus on patients’ subjective views.

I have argued above, in reflecting on the participant observation, that using my subjectivity as a clinician and researcher in the study was justifiable and productive rather than invalidating, but some critics may not agree.
5.6 Dissemination

A plain English summary of the study is in preparation and will be sent to all participants. Two journal articles are in preparation for submission in early 2019. I also plan to attend the International Society for Traumatic Stress Studies (ISTSS) annual conference in November 2019.

5.7 Suggestions for Future Research

*Cultural applicability*

It would be useful to explore the views of different populations groups in order to tailor treatment to varied needs. For example, refugees and asylum seekers are often seen as having similar needs when in fact their different immigration status may require different kinds of help. It would be interesting to explore if the views of refugees and displaced people about treatment are different when they are in non-Western countries, compared to refugees who have settled in the UK. Given that understandings of health are influenced by cultural values, it would be interesting to know if and how such values change in different settings. It would also be useful to know whether there is any difference in patient views on psychotherapy between those who experienced traumatic events in childhood and those who experienced interpersonal trauma as adults.

*Third Sector collaboration*

If we look again at what Seager said about psychological safety and attachment (2006), a hospital may be the location for new attachments. It must be remembered that according to NICE guidelines (NCCMH, 2005), a lack of social support increases the risk of developing PTSD. NHS staff may be replacing temporarily other forms of interpersonal support such as families and social organisations. This may be particularly necessary for refugees who have left their social support networks behind, as well as those who have migrated to London from other parts of the UK. However, given current pressures on the NHS, it cannot be a long-term solution, and an investigation of how social networks can be developed, possibly in collaboration with Third Sector groups, is an area that would merit future research.
Overlap between BPD and CPTSD?

In the initial reading for this study, the issue of differential diagnosis arose, particularly the similarity in aspects of symptoms of Borderline Personality Disorder, BPD, and Complex PTSD. It would be useful to study this issue further, particularly in the light of suggestions made by some clinicians that gender bias may be involved in diagnosing women with BPD (see Appendix O. Differential diagnosis for further discussion).

Methodology

In terms of methodology, there were interesting questions around combining psychoanalytic theories with social science methods such as action research, and these merited further study. On a more practical level, there could be important learning for research as well as clinical practice to investigate how matching up researchers and interviewees with similar diagnoses affects their symptoms, particularly those around relating to others and feelings of worthlessness.

5.8 Evaluation and Conclusion

Keen and Otter (2014, p. 45) have offered a helpful set of criteria for evaluating qualitative research: credibility, transferability, dependability, and confirmability.

Credibility examines the degree to which the findings make sense. In my study the participants were all given a transcript of their interviews and the researchers commented extensively, as well as deciding themes for analysis. Triangulation of the data was provided through an adjunct participant observation.

Transferability can be judged by giving a detailed picture of the research setting so that readers may decide whether its findings could be applied elsewhere. I have described the team and its location in inner London in some detail to show how the setting may be considered typical of other community settings in the UK’s inner cities.

Dependability can be evaluated through an audit trail which includes documenting data and methodology. I have provided extensive quotations from transcriptions as well as some illustrative examples in Appendices K and L. I have also described in detail the methods used.
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Confirmability consists of appraising the quality of a study and I have offered a reflexive analysis of my role, as well as making transparent my background and motivation in undertaking it.

In conclusion, the contributions of the research can be summarised as follows:

- The research offers a timely contribution to knowledge about patient views on psychotherapy for CPTSD through identifying principles for successful treatment. The most significant principle was that following the damage done by human mistreatment, rebuilding relationships with other people was the path to recovery. It was necessary to take time for trust to be re-established. This is reflected in the study’s title, “Getting Back in Through Others”, which is a quotation from a participant, Researcher 2. This was the answer to the research question.
- The study’s application of psychoanalytic thinking on attachment gives added weight to the findings through explaining how and why patients with the diagnosis of CPTSD may need the kind of treatment they identified.
- The study contributes to research methodology through developing a participatory method with a patient group.
- The study’s findings on patient views have additional credibility because of its participatory approach.
- The research contributes to clinical practice through establishing that research participation can promote recovery for patients with the diagnosis of CPTSD.
- The research is opportune for the next consultation on the NICE guidelines on treatment for Complex PTSD as the new diagnosis is set to be approved in May 2019.
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APPENDICES

APPENDIX A. ICD-11 proposal for Complex PTSD

Revision of ICD-10 Mental and Behavioural Disorders
Department of Mental Health and Substance Abuse
World Health Organization

ICD-11 Content Form for Mental and Behavioural Disorders
for Intellectual Developmental Disorders

Working Group: Stress-related disorders [edited by Marylene Cloitre, Inka Weissbecker, Andreas Maercker]

Date Submitted: January 31, 2012

I. Category Name (Required):
Complex PTSD

II. Relationship to ICD-10 (Required):
A. Equivalent ICD-10 Alphanumeric Code and Category Name:
62.0 Enduring Personality Change Associated with Catastrophic Events (EPCACE)
B. Relationship of Proposed Category to ICD-10:
1. Same category name as ICD-10; no or minor changes in concept
2. Same category name as ICD-10; substantive changes in concept
3. New category name; no or minor changes in concept
4. New category name; substantive changes in concept
5. New category (does not exist in ICD-10)

III. Primary ‘Parent’ Category (Required):
Traumatic stress disorder

IV. Secondary ‘Parent’ Categories (if Applicable):
N/A

V. ‘Children’ or Constituent Categories (if Applicable):
N/A

VI. Synonyms (if Applicable):
Disorders of Extreme Stress (DES), Disorders of Extreme Stress Not Otherwise Specified (DESNOS), Malignant PTSD

VII. Definition (Required):
Complex PTSD arises after exposure to a stressor event typically of an extreme or prolonged nature and from which escape is difficult or impossible. The disorder is characterized by the core symptoms of PTSD as well as the development of persistent and pervasive impairments in affective, self and relational functioning, including difficulties in emotion regulation, beliefs about
VIII. Diagnostic Guidelines (Required):

Exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible such as torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, domestic violence, and childhood sexual or physical abuse.

Presence of the core symptoms of PTSD (re-experiencing the trauma in the present, avoidance of reminders of the trauma, and persistent perceptions of current threat).

Following onset of the stressor event and co-occurring with PTSD symptoms, there is the development of persistent and pervasive impairments in affective, self and relational functioning including problems in affect regulation, persistent beliefs about oneself as diminished, defeated or worthless, persistent difficulties in sustaining relationships [1,2,3,4,5].

The stressors associated with Complex PTSD are typically of an interpersonal nature, that is are the result of human mistreatment rather than acts of nature (e.g., earthquakes, tornadoes, tsunamis) or accidents (train wrecks, motor vehicle accidents).

In addition to the typical symptoms of PTSD, Complex PTSD is characterized by more persistent long-term problems in affective, self and relational functioning. Problems in all three areas are often co-occurring.

Problems in affect dysregulation are characterized by heightened emotional reactivity to and difficulty recovering from minor stressors, violent outbursts, reckless or self-destructive behaviour and tendency towards dissociative states when under stress. In addition, there may be emotional numbing, particularly a lack of ability to experience pleasure or positive emotions.

The individuals also develop persistent beliefs about himself or herself as diminished, defeated or worthless accompanied by deep and pervasive feelings of shame, guilt or failure related to, for example, not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others.

There are also persistent difficulties in sustaining relationships. This may present in a variety of ways and is characterized primarily by difficulties in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively there may be occasional intense relationships but the person has difficulty sustaining them.

References or other basis for development/specification:
Evidence for the specific symptoms (in excess of PTSD) associated with prolonged or repeated exposures to extreme stressor events has been provided by three empirical papers of three different populations which had each experienced exposure to prolonged stressor events [1,2,3]. Problems in emotion regulation (including dissociation), negative beliefs about self, and disturbances in relational capacities were investigated and found to be frequently occurring symptoms (in the top 20%) in all three studies. The above characterization of Complex PTSD, is consistent with the recommendations made in an expert opinion paper on the IDC-10 EPCACE [4] and in an expert consensus report on Complex PTSD published by the International Society of Traumatic Stress Studies (ISTSS)[5] .


Association of affect regulation difficulties with reckless, self-injurious behavior and dissociation is supported by

The presence of emotional numbing, and inability to experience pleasure or positive emotion emotions exposures has been frequently documented [7,8, 9] and has received support in recent neuroimaging studies [9,10].


Description of varying somatic complaints across cultures including “Malignant PTSD”


IX. Functional Properties (if Applicable):
Identify use of Activity Limitations or Participation Restrictions as a part of the Definitions (Section VII) or Diagnostic Guidelines (Section VIII), and provide the rationale for such inclusion:
N/A

X. Temporal Qualifier (if Applicable): N/A

XI. Severity Qualifier (if Applicable):

XII. Differential Diagnosis (as Appropriate):
In contrast to PTSD, Complex PTSD has the added elements of sustained and pervasive difficulties in emotion regulation, self-appraisal and interpersonal functioning. [1]
Complex PTSD can be distinguished from Borderline Personality Disorder in that the latter is strongly characterized by fear of abandonment, shifting identity and frequent suicidal behaviours. In Complex PTSD, the fear of abandonment is not a requirement of the disorder and self-identity is consistently negative rather than shifting. While suicidal behaviours may be reported, they occur much less frequently than in in BPD samples [2] and are not the focus of treatment. BPD does not require the presence of a stressor event nor the core symptoms of PTSD to be diagnosed. [1,2]
While both Avoidant Personality Disorder (APD) and Complex PTSD are characterized by avoidance of relationships, the motivation in avoidant personality is driven by the need to be liked and dependence on the good opinion of others. Complex PTSD relationship avoidance is characterized by fear of harm from others or a dismissive attitude about relationships. APD does not require the presence of a stressor event to be diagnosed. [1]
Paranoid Personality Disorder (PPD) is defined by persistent and pervasive expectations that others are likely to do personal harm where these beliefs are based in no or little experience and occur regardless of circumstance. In Complex PTSD, fear of harm is characterized as a state-like phenomenon.
XIII. Differentiation from Normality (as Appropriate):
The symptoms related to emotion regulation, self-appraisal and interpersonal difficulties differ from normality where in the later case such symptoms occur but are mild, wax and wane or resolve entirely across time and without intervention. In Complex PTSD such symptoms are severe, persistent and pervasive and are unlikely to remit without treatment.

XIV. Developmental Presentations (as Known and Relevant):
Among children, the core symptoms of PTSD may differ in that re-experiencing symptoms can be observed in repetitive play, while emotion regulation and interpersonal difficulties may be observed in regressive and/or aggressive behaviours towards self or others. In adolescence, substance use, risky behaviours (unsafe sex, unsafe driving), and aggressive behaviours may be particularly evident as expressions of emotion regulation and interpersonal difficulties [1].

References or other basis for development/specification:
as in civil war and community violence which can occur for decades, the disorder may be present while the exposure is ongoing. The symptoms of Complex PTSD can endure for several years. However individuals with Complex PTSD can recover with psychosocial intervention. [1]

References or other basis for development/specification:

XVI. Associated Features and Comorbidities (as Known and Relevant):
A. Associated symptoms and psychiatric disorders
Other symptoms commonly present but not essential for diagnosis include suicidal ideation and behaviour, and substance abuse, both of which have been related to emotion regulation difficulties [1]. Significant depression [2] and psychotic episodes [3] have also been observed.

B. Associated physical symptoms and medical conditions
Somatic complaints are frequently present but vary by culture [6] and may result from the physical adversities that typically co-occur with prolonged trauma (e.g., inadequate food, clothing, shelter, or experiences of physical punishment, torture, excessive labours, sexual or other forms of physical exploitation).

C. Associated laboratory findings
N/A

D. Associated Functional Limitation and Restrictions
Functional impairment is significant and includes lack of or limited employment and financial resources, disregard of health status, lack of or limited engagement in family life, low or no social support and transient residence.


XVII. Culture-Related Features (as Known and Relevant):
There are variations in somatic symptoms and presentation of dissociative symptoms by culture [1]. The meaning of the symptoms and the traumatic events are also subject to wide cultural variations [1].

XVIII. Gender-Related Features (as Known and Relevant):
Systematic studies of gender differences as related to risk of Complex PTSD or in symptom profile have not been completed. To date, gender has not been found to be a predictor of Complex PTSD [1] and the gender ratio for the disorder has differed by culture [2].

XIX. Assessment Issues (as Relevant):
Culture-sensitive and competent assessment processes with rapport, trust and secure and with knowledge of local idioms and explanatory beliefs are vital. Some survivors, particularly those who have experienced sexual violence, are extremely reluctant to recount details and may be penalized by their families and society if their experiences become known. Assessment may need to be done at the pace and readiness of the survivors with frequent breaks and time-outs. Secure and structured environment may need to be available or created. Support and follow-up resources should be available before embarking on assessment. An interrogative style, and direct and repetitive questioning, should be avoided in survivors of sexual violence and severe ill-treatment. Gender-matched interviewers may be needed for survivors of sexual violence.
PATIENT VIEWS ON THERAPY FOR CPTSD

APPENDIX B. HDAS Search Strategy

Welcome to HDAS
Please visit the help file for tips, guides and videos on how the features work.

OpenAthens Authentication and Administration Services Maintenance will be performed on Tuesday 14th August between 07:00 and 09:00 UK time. No service disruption is expected.

Current search strategy: Day one

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</tr>
<tr>
<td>Medline</td>
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</tr>
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<td>Medline</td>
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</tbody>
</table>
PATIENT VIEWS ON THERAPY FOR CPTSD

1. Cognitive behavioral therapy for PTSD: The role of complex PTSD on treatment outcome
   Author(s): Leitgeb, Michele
   Source: Journal of Aggression, Maladjustment & Trauma, May 2014, vol. 23, no. 5, pp. 446-452
   Publication Date: May 2014
   DOI: 10.1080/19322677.2014.910446
   ISSCN: 1932-6771
   Database: PsycINFO
   Show Abstract

2. Contextual therapy
   Author(s): Solco, Steven N.
   Publication Date: 2009
   Database: PsycINFO
   Show Abstract

3. From traumatic language to posttraumatic language: The development of language in therapy according to the "phenomenon of hope" model
   Author(s): Lev, Cht
   Source: Psychiatric Social Work, Jan 2017, vol. 34, no. 1, p. 54-74
   Publication Date: Jan 2017
   DOI: 10.1080/08902391.2016.1278394
   ISSCN: 1522-0078
   Database: PsycINFO
   Show Abstract

4. The therapeutic relationship as a critical intervention in a case of complex PTSD and OCD
   Author(s): Atkinson, Peter G.
   Source: Beyond diagnosis: Case formulation in cognitive-behavioural therapy (2nd ed.); 2015, p. 16-329
   Publication Date: 2015
   Database: PsycINFO
   Show Abstract
PATIENT VIEWS ON THERAPY FOR CPTSD

15. [Complex PTSD following early-childhood trauma: emotion-regulation training as addition to the PTSD guideline]
   Author(s) Thomsen, K; Dornecchi, E; van Bommel, A; J.L.; Vollman, D.J; Smi, J; Het al.
   Source Tijdschrift voor Psychiatrie; 2015, vol. 57 (no. 3), p. 171-182
   Publication Date 2015
   ISSN 0030-7339
   Database Medline
   Show Abstract

   Author(s) Ooter, Lewis & Green, Melanie & Oner, Marc G
   Publication Date 2006
   ISSN 1595-3993
   Database Medline
   Show Abstract

   Author(s) Kraster, L; Heinz P; Pflizer F; Schnarch R; Autsch W & et al.
   Language German
   Publication Date Jun 2018
   DOI 10.1159/000483862
   Database EMBASE
   Show Abstract

18. The role of an endocrinologist in a women's mental health clinic.
   Author(s) Thew C; W.C; Dar M; Kuckin J
   Source Psychoneuroendocrinology; 2017, vol. 82, p. 34
   Language English
   Publication Date Sep 2017
   Database EMBASE
   Show Abstract

   Author(s) Pfaff A; Adlerhoff J; Becke-Madhura M; Scharer M; Rof K & et al.
   Language German
   Publication Date 2012
   ISSN 0575-1561
   Database EMBASE
   Show Abstract

1 (strategy=479574/saved&page=1&pagesize=100&saved-panel)
12 September 2017

Ms Catherine Matheson
Senior Psychotherapist
South London and Maudsley NHS Trust
IPTT, 4th floor Ladywell Unit
University Hospital Lewisham
London
SE13 6LH

Dear Ms Matheson

Study title: What are patient views on psychological therapy for the new diagnosis of Complex Post-traumatic Stress Disorder: a participatory study with service users

REC reference: 17/LO/1391
Protocol number: 1617/038 Exeter
IRAS project ID: 230818

The Research Ethics Committee reviewed the above application at the meeting held on 29 August 2017. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Favourable opinion
The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. In the “What does taking part involve?” section of the Participant Information Sheet add the following sentence: “Please let us know if you would like to look at a transcript of the interview.”

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).


Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identifying centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

**Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.
If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Summary of discussion at the meeting

Social or scientific value; scientific design and conduct of the study

Complex post-traumatic stress disorder (CPTSD) was post-traumatic stress disorder (PTSD) plus three extra symptoms. The Committee was concerned that the three additional criteria that turned PTSD into CPTSD could be found in people with other conditions, such as personality disorders, which might lead to people being involved in the study who did not have CPTSD.

You said that all study participants would have a diagnosis of CPTSD. It had originally been intended that all interviewers would also have a diagnosis of CPTSD, but this had been abandoned in favour of allowing anyone interested in becoming an interviewer to do so.

The Committee was content that there would be no confounding issues caused by participants with other conditions.

Recruitment arrangements and access to health information, and fair participant selection

Research projects often had to deal with participants withdrawing from studies but this project came with the risk of interviewers dropping out as well. The Committee asked if this would make it difficult to undertake the research.

You said this was a concern. However, having a peer support coordinator as a permanent member of staff meant there would be good support for interviewers which would hopefully minimise attrition. Additionally the SLaM volunteer manager was prepared to support the training of interviewers.

The Committee was pleased that this aspect of the research had been considered.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

There were a lot of questions in the interview schedule and the Committee was not certain they could all be fitted into one hour.
You said that the hour was just a guideline. Some interviews might be shorter than an hour as some patients did not wish to say a lot. Others, of course, had more to say and no one would be cut off if they wanted to continue past one hour.

The Committee normally liked participants to be offered a copy of interview transcripts so they could review it for errors. However, in this case the Committee was concerned that this would add to their trauma. The Committee asked if it would be possible to offer participants a copy of the transcript.

You said it would be possible.

The Committee determined that it would be appropriate to offer a copy of the transcript to participants but make it clear they did not have to review it if they did not wish to.

**Suitability of the applicant and supporting staff**

The Committee was excited to see a study with members of the public helping conduct the research. However, they wanted to be assured that these people would have sufficient training to ensure the validity of the study and their own safety.

You said this had been discussed with the patient involvement manager. This type of involvement had been done before and it had been found that the biggest problem was that volunteers were usually very well disposed to their therapists and the trust. This made it very difficult for them if an interviewee expressed negative feelings. Interviewers would have at least two training sessions and while undertaking interviews they would also have weekly clinical supervision.

The Committee was assured that interviewers would have sufficient training and support.

The Committee was concerned that having non-professionals conducting the interviews might lead to boundary issues and asked if the training would include that. The Committee also asked if there would be an assessment of competency before the interviewers were allowed to interview participants.

You said the training would definitely cover boundary issues. Regarding competency, there would have to be a decision made about that for each person. If it was thought that someone would not be able to stick to the boundaries, or would become too distressed themselves, then we would have to tell them that they would not be conducting any interviews. Ms Matheson also said that they might decide it wasn’t for them as well.

The Committee accepted that the research team would ensure that the interviews were only conducted by people able to do them within the guidelines.

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

**Approved documents**

The documents reviewed and approved at the meeting were:
Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/
With the Committee’s best wishes for the success of this project.

Yours sincerely

Mr Robert Goldstein
Chair

E-mail: nrescommittee.london-westminster@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: Mrs Gail Seymour, University of Exeter
Ms Jennifer Liebscher, South London And Maudsley NHS Foundation Trust
London - Westminster Research Ethics Committee  
Attendance at Committee meeting on 29 August 2017

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Calvin Chen</td>
<td>Clinical Research Associate</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mr Robert Goldstein</td>
<td>Chair - Economist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs Jean Gourlay</td>
<td>Clinical Psychologist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Maurice Hoffman</td>
<td>Retired Teacher</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Erika Kennington</td>
<td>Research Funder</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Christopher Mellor</td>
<td>Barrister</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mrs Rosemary Morgan</td>
<td>Financial Services (retired)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mr Malcolm Morton</td>
<td>Practice Manager (Retired)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dr Michael Newell</td>
<td>Lecturer in Sport and Exercise Nutrition</td>
<td>No</td>
<td></td>
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<tr>
<td>Dr Yash Patel</td>
<td>Senior Clinical Project Manager</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mr Michael Puntsis</td>
<td>Vice-Chair - ICU Anaesthetist</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dr Alan Swann</td>
<td>Occupational Physician</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs Anna Szmigina</td>
<td>Principal Pharmacist - Acute Medicine</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Dr Ruth Williams</td>
<td>Consultant Paediatric Neurologist</td>
<td>Yes</td>
<td></td>
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Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
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<tbody>
<tr>
<td>Ms Rachel Katzenellenbogen</td>
<td>REC Manager</td>
</tr>
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</table>

Written comments received from:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Mr Malcolm Morton</td>
<td>Practice Manager (Retired)</td>
</tr>
</tbody>
</table>
**Study title:** Patient views on Psychological Therapy for Complex Post-traumatic Stress Disorder

**What is the purpose of the study?**
From 2018 there is likely to be a new diagnosis called Complex Post-traumatic Stress Disorder. The NHS will have to consider what kind of therapy could be useful for this and we want to ask service users what they think about it.

As you had some of the symptoms of PTSD which were addressed in your therapy, we would like your views on this. It would mean coming to the Ladywell Unit for one hour to be interviewed by one of our researchers who has also been a service user. The researchers are specially trained in interviewing, including confidentiality. The interviews will then be analysed by one of our psychotherapists, Catherine Matheson, who is doing a doctoral study on Complex PTSD.

**Why have I been invited?** We are asking people who may have had some of these symptoms to consider what kind of psychological treatment was helpful or not for them. We are also interested in knowing if anything else was useful, such as exercise, family support, gardening, religion etc. The interviews will be carried out by people who have used services themselves.

**Background**
The diagnosis of CPTSD may apply to people who have experienced extreme traumatic events, such as torture, civil war, organized violence, domestic violence and childhood abuse, and then go on to suffer from the symptoms of PTSD and CPTSD. Not everyone who has such experiences will go on to have such problems. Psychotherapists and psychologists are currently discussing what might work best with such symptoms.

**Do I have to take part?** No. It is entirely voluntary and your care, or access to care, will not be affected in any way if you choose not to take part or decide to withdraw. You may withdraw at any time by informing Catherine Matheson or the researcher who will be interviewing you.

**What does taking part involve?**
After reading this Information Sheet, you may want to take some time to think about it. After at least two weeks, we will call you to discuss any questions or
PATIENT VIEWS ON THERAPY FOR CPTSD

concerns. If you decide to go ahead, you will be invited to come to the Ladywell Unit for a discussion with a volunteer researcher who has experience of mental health services. You will be asked to sign a consent form by the researcher and there will be another chance to discuss any concerns. If you are a Tamil speaker, you will be interviewed by a researcher who speaks Tamil. All volunteers will have had special training to do the research. You will not be expected to disclose your personal history. It will be an informal talk based on questions about the therapy you have recently received and you will be encouraged to give your views as fully as you want to. It could take up to an hour. The discussion will be audio-recorded and the recording will be given to Catherine Matheson. She will transcribe and analyse recordings which will be kept anonymously. Your identity will be kept confidential. Please let us know if you would like to look at a transcript of the interview.

What are the possible benefits of taking part?
This is an opportunity for patients to take part in research both as respondents and interviewers. Although there will be no immediate benefit to participants, they may be able to influence the future development of treatment for the new diagnosis of CPTSD.

What are the possible disadvantages and risks?
Although participants will not be expected to disclose personal histories, it may be that some people could find it upsetting to consider their treatment. If this is the case, please contact Catherine Matheson on 020 3228 0267 and she will arrange for a clinician to talk to you.

What will happen to the results of the research?
The study will be written up as a thesis for the University of Exeter by Catherine Matheson. It will also be written up as an academic journal article and submitted for publication. All your details will be anonymous and you will not be identified in any way. A copy of the final report will be available for you to read from c.matheson@nhs.net. No personal data will be stored outside the NHS record system. Anonymous research data could be kept for 5 years on a password-protected personal computer to which only Catherine Matheson has access.

What if there is a problem?
If you have any concerns about the study, you should first speak to Catherine Matheson. If you would like to complain formally, please contact Elizabeth Weightman at the University of Exeter on E.Weightman@exeter.ac.uk or Tel. 01392 725762.

Who has reviewed the study?
The NHS Research Ethics Committee based in Westminster has approved the study No. 230818

Contact details: If you would like more information, please contact Catherine Matheson on 020 3228 0267 or c.matheson@nhs.net
How would you describe how you are at the moment in terms of emotional health?

What about your relationships with other people - how would you describe them?

What did you feel about techniques you were taught to feel more stable, such as grounding to keep you in the present, breathing or sleep hygiene, or the Safe Place?

Which techniques did you find most helpful?

Which techniques, if any, do you still use, and why?

How did you feel about talking about your traumatic experiences in therapy?

How did it affect you, talking about it with your therapist? If it helped you, how was that? Or if not, why not?

If you did EMDR, how did you feel about it? What was helpful/not helpful?
PATIENT VIEWS ON THERAPY FOR CPTSD

If you were in a group, how did you feel about it? What was helpful, not helpful?

If you did Narrative Exposure Therapy (with stones and flowers on a timeline at the beginning), how did you feel about it? What was helpful/not helpful?

How did your feelings about yourself change over the course of therapy?

What happened to make you change?

How long did it take before you began to feel change?

What did your therapist do which made you feel better?

What did your feelings about other people change over the course of therapy? How did therapy contribute to this change?

What other things helped you when you were feeling bad—sport, work, social activities, friends, family, yoga, meditation, and gardening are some that people have talked about?

How has your life in general changed since you finished therapy?
12/10/2017

Name
address

Do you want to help with research at the Ladywell Unit?
Training in research provided

Dear

I am contacting you because you attended psychotherapy with our team to ask if you are interested in helping with research here at the Ladywell Unit.

From 2018, there is going to be a new diagnosis of Complex Post-traumatic Stress Disorder (see enclosed Information Sheet), which means the NHS will have to decide what treatment to offer. We want to know what patients think about this by interviewing them. We want the interviews to be carried out by former patients because this may result in more accurate information.

The research involves:
Interviewing at least 3 former patients about their treatment here (personal histories will not be disclosed, just treatment)
Attending one day of training in how to do research interviews
Attending one day of training in how to be a volunteer with SLaM
Attending research discussion meetings to talk about the issues

Altogether it may take about 5-6 days over several weeks.

If you are interested or would like to ask questions before deciding, please e-mail me on c.matheson@nhs.net, or give me a call on 0203 228 0267 before Friday 27 October.

Yours sincerely,

Catherine Matheson,
Senior Psychotherapist
PATIENT VIEWS ON THERAPY FOR CPTSD

APPENDIX G. Researcher Information Sheet

Researcher Information Sheet-v2
13/10/2017

Study title: Patient views on Psychological Therapy for Complex Post-traumatic Stress Disorder

What is the purpose of the study?
From 2018 there is likely to be a new diagnosis called Complex Post-traumatic Stress Disorder, CPTSD. The NHS will have to consider what kind of therapy could be useful for this and we want to ask service users what they think about it. We also want service users to help with doing the research as this could result in more accurate information.

Background
The diagnosis of Complex PTSD may apply to people who have experienced extremely traumatic events, such as torture, war, domestic violence and childhood abuse, and then go on to suffer from the symptoms of PTSD and CPTSD. Not everyone who has such experiences will go on to have such problems. Psychotherapists and psychologists are currently discussing what might work best with such symptoms.

Why have you been invited to be a researcher?
As you have experience of some of the symptoms of PTSD which were addressed in your therapy, we are inviting you to help with this research. It would mean coming to the Ladywell Unit for training and supervision, as well as interviewing other service users here.

What kind of training is on offer?
Training as a volunteer for SLaM which includes how to work with service users. This would take one day at the Ladywell Unit. You would need to pass a Disclosure and Barring Service (DBS) check, do an Occupational Health questionnaire, and supply two references for the training. This is because the research involves contact with vulnerable adults. Support will be given to complete these steps if needed.

Training in how to do research interviews. This will be held at the Ladywell Unit and will also take one day.

What does being a researcher interviewer involve?
If the training is completed successfully, you will interview other service users about their views on psychotherapy for Complex PTSD. We are asking people who may have had some of these symptoms to consider what kind of psychological treatment was helpful or not for them. We are also interested in knowing if anything else was useful, such as exercise, family support, gardening, religion etc. The interviews will be an informal talk based on
PATIENT VIEWS ON THERAPY FOR CPTSD

questions about the therapy which was offered and questions will not be asked about personal histories.
Each researcher may do up to four interviews of about one hour which you will record. The interviews will then be transcribed and analysed by one of our psychotherapists, Catherine Matheson, who is doing a doctoral study on Complex PTSD. If you are interested, you will have the opportunity to help analyse the information. Altogether the researchers’ activities could take 5 days over several weeks.

Will researchers be paid?
Researchers will not be paid for training courses or supervision, but vouchers will be given for doing interviews and attending the analysis meeting at the rate of £10 an hour.

Do you have to take part? No. It is entirely voluntary, and your care, or access to care, will not be affected in any way if you choose not to take part or decide to withdraw. You may withdraw at any time by informing Catherine Matheson.

What are the possible benefits of taking part?
This is an opportunity for you to receive training and take part in research as interviewers. Researchers will be registered as SLaM volunteers which means an opportunity to participate in voluntary work afterwards. There may also be a chance to take part in other research through the INVOLVE register. (This is a way to become involved in the planning and development of services for SLaM.) There will be some small financial payment through vouchers for research done. This is unlikely to be more than £50 per person. Researchers may also like to consider that they may be able to influence the future development of treatment for the new diagnosis of CPTSD.

What are the possible disadvantages and risks?
Although interviewees will not be expected to disclose personal histories, it may be that you could find it upsetting to listen to accounts of treatment. If this happens, please contact Catherine Matheson on 020 3228 0267 and she will arrange for a clinician to talk to you.

What will happen to the results of the research?
The study will be written up as a thesis for the University of Exeter by Catherine Matheson. The participation of service users in research will also be part of the study. It will be written up as an academic journal article and submitted for publication. All your details will be anonymous and you will not be identified in any way. A copy of the final report will be available for you to read from c.matheson@nhs.net. No personal data will be stored outside the NHS record system. Anonymous research data could be kept for 5 years on a password-protected personal computer to which only Catherine Matheson has access.

What if there is a problem?
If you have any concerns about the study, you should first speak to Catherine Matheson. If you would like to complain formally, please contact her supervisor, Dr Elizabeth Weightman at the University of Exeter on E.Weightman@exeter.ac.uk or Tel. 01392 725762.
PATIENT VIEWS ON THERAPY FOR CPTSD

Contact details: If you would like more information, please contact Catherine Matheson on 020 3228 0267 or c.matheson@nhs.net
Title of Project: Patient views on Psychological Therapy for Complex PTSD

Name of Researcher: ____________________________

I confirm that I have read the information sheet dated.................... (version.............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.

I agree to take part in the above study.

Name of Participant ____________________________ Date __________________ Signature __________________

Name of Person taking consent ____________________________ Date __________________ Signature __________________
Dear [Name],

I am writing to you because you have attended psychotherapy here at the Ladywell Unit and we are now doing research into what people thought of their treatment. The reason we are doing this is that there is going to be a new diagnosis called complex post-traumatic stress disorder. The NHS will have to consider what kind of therapy could be useful for this and we want to ask clients what they think about it.

As you have some of the symptoms of PTSD which were addressed in your therapy, we would like your views on this. It would mean coming to the Ladywell Unit for one hour to be interviewed by one of our researchers who has also been a service user. The researchers are specially trained in interviewing, including confidentiality. The interviews will then be analysed by one of our psychotherapists, Catherine Matheson, who is doing a study on complex PTSD. She will write up the study to publish in journals. All information about you will be kept confidential and any publications will not identify you.

You don’t have to participate if you don’t want to. It won’t disadvantage you in any way. If you do take part, what you will gain is an opportunity to contribute to knowledge about what treatment works from your personal experience.

If you would like to take part or would like to know more, please e-mail Catherine Matheson on c.matheson@nhs.net or give her a call on 02032280267 to discuss.

Thank you for your time.

Catherine Matheson,
Senior Psychotherapist.
R2 Interview with Q. Jan.30, 3018.  
R=researcher. Q=participant. 

R2: (name) I will start with the first question - How would you describe how you are at the moment in terms of your emotional health, your feelings?

Q: My feelings, I feel better now, from the day when I came here, I started to be more strong and when I see something because I try to ignore the past I think ?? yeah I try to ignore the past, I feel more strong, really it’s more strong.

R2: OK, what about your relationship with other people, how would you describe them?

Q: I get some because I think everybody is bad but now some they are good some is not good, but now I started getting more in touch with people. Yes, but before I don’t trust people and I feel I hate everybody. I’m so sorry but now I started to be close to people, people they show me they are all good, not all bad, but some good yes.

R2: So it is improved

Q: Yes, really, really I improved, I am not ..

R2: OK. Question 3: what did you feel about the techniques you were taught about feeling more stable, such as grounding to keep you present, breathing or sleep hygiene or the safe place? You know grounding where you the grounding technique, did you do it and then there was the breathing?

Q: OK yeah when I feel like fear or something, I breathe in and out, in and out, so I feel I don’t know, strong and then I said OK sometimes when I feel like scared sometimes it has happened and I scared maybe someone maybe but when I breathe I say no it’s not good, no it’s not right, no, I have to be strong. No so I yeah it’s like that breathe in and breathe out ?? has helped me a lot before when I panic I feel you know but when I breathe in I breathe out, I feel more strong, I start to say let me go (name) nothing gonna happen to you yeah nothing happened to me yes.

R2: So that helped.

Q: Yeah, a lot.

R2: So out of all the techniques you were taught, do you still use them, like the breathing for example?

Q: Yes

R2: OK you use the breathing

Q: Yes
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R2: is that the only one you use or do you use any other techniques such as the safe place?

Q: Yeah ok breathe in and breathe out is helped me sometimes I use but sometimes no because I improve sometimes but before I use was help me a lot, was help me really, really a lot.

R2: Oh ok it says here why did you find it helpful, this one maybe was there a reason why you found this one really helpful for you?

Q: Which one?

R2: The breathing.

Q: Even when I talked before when I came here, I was my life already gone my life was already gone, but I spoke to Miss Catherine, she tried to tell me because when I came I talked to her she tried to really she helped me a lot, a lot, I tell you a lot because I was thinking maybe this you know it's difficult to explain. Because when before I was thinking when I see someone and I think maybe someone that one gonna hurt me like that when because I was spoke to us and say you know maybe it's not you know I tried to say it's not right. It's what I think is not good, yeah, she was trying to tell me no trying to avoid that dirty voice who told me, but it concentrated it is not right. I put in my mind maybe it is not right when sometimes I was scared to go out from the house I stay in the house and scared to go out just in the window towards outside. When I see someone maybe parking maybe someone passing, maybe that one gonna hurt me no I scared to go out. When I came here and I started to talk to her, she tell me she try to make me like to I avoided that I avoided that who come in your mind really I tried to follow what she told me absolutely. I feel more improved because when I said no this one gonna hurt me and I said not it's not it's not right, it's not gonna hurt me, no no, yes, yes, yes, then I go out. Nothing happened to me, nothing but before because was full in my mind this one gonna hurt me, but people are gonna kill me like in my mind, but now I try to say no it's not good it's not true not it's not no it's not because she told me no, no it's not to try to ignore that voice who come in my mind. So now I started to see nothing can happen. I went outside I said no nobody hurt me nobody touch me. I said yeah it started to be like that absolutely helped me a lot. I tried to use oil what she told me it's I smile I started to be back to back here. I appreciate it I really am so happy, yes, I am so happy.

R2: It’s good to hear. How did you feel talking about you, know the traumatic experiences you went through the bad experiences, in therapy how did you feel about talking about it in therapy?

Q: OK it depend because before I was thinking all the time was in my mind. I was fallen in my mind when I sleep I dream that, when I woke I think that, all that time I think maybe they come for me, they hear you know I was walking watch on my back like this always, I watch on my back but even because now I talked a lot, maybe it’s helped me because I talked to her because it was full in my mind on my head when I spoke to her, because I came like a very maybe so many times here, as I don’t know it’s going like a daze, it’s better going, going, going, going, now I try to but the truth I don’t like to talk about that.
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R2: Oh, ok so it is a bit difficult to talk about that?

Q: Yeah very difficult that’s why I try to ignore. When it started coming in my mind I think nice music what I like I started to put that music in my mind, I started to sing not loud, but in my mind I expected to remember the good time, I tried to ignore because I don’t like to talk about that because when I started to talk I feel my understand yeah I don’t like to talk really, really because I try to forget and to think the good thing in my life.

R2: So which leads onto the next question thank you for that. Do you think it was useful to focus on the trauma to speak about it was it useful to you or? Was it useful to think about the trauma, to even talk about it, was it useful to you in your..

Q: Yes because if I didn’t tell her if I didn’t tell her she didn’t tell me what to do. It’s better because was help me a lot because before was nobody help me. I was like that but when I spoke to her I tell her, I cried, I tell her, I cried, I tell her, and she get something to help me. She tried to tell me: no, when you think that don’t stop to think of that thing that, if I didn’t tell her nobody can help me because it was on my mind, like to fear go out, like to fear everybody, not trust, I was not trust anybody in the world, I tell the truth, and I think everybody who gonna be close to me gonna kill me, was in my mind. But if I didn’t tell her I couldn’t get more improvement now because now I stay with people, people they close to me. Yeah to spoke to her I think when you spoke to someone is better I think it help, it’s better to keep it because I was keep that problem in my mind and I feared to tell anybody because I was not trust anybody, but when I came to her I feel really to tell her. When I tell her everything what I feel she helped me it helped me, I don’t know my English is not good but …

R2: No, it is fine I understand.

Q: It’s better to talk to that problem because when you talk you get more help. Yes it’s difficult time to talk that but when you talk to someone who help you, absolute it’s help it help a lot because I see my life now, thank you very much I see my life started to be, yeah, to be back.

R2: Ok that’s nice.

Q: It’s not maybe like when I walk like a friend to talk about that all the time it’s not good when I talk with like a friend someone to remind me. But when you talk to someone who gonna help you absolutely it help a lot it helped a lot because for me I see my life I talk about me I don’t know other people but about me, because when I came to meet her and spoke to her, I expected to be stronger because when I came I was walking from here to I walk from here to home, but from here when I walk I was strong and the walk because I was from here I said nothing gonna happen to me because she already talked to me I said (name) no don’t when you think that someone gonna hurt you it is not true, it is not right go and I tried to follow what she told me and I reach at home I feel stronger I feel, yes another good thing she told me, when you feel that is coming that bad past, think a good thing, then I think the good day, and when it come in my mind
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I said oh and no I remember another good day. It helped me a lot and now I started I got a job I started to work.

R2: That’s good congratulations.

Q: Before I was fear anybody and I don’t trust anybody I went to college one year no friend no nothing see because it was not here no friend no nothing. When I came and started to talk to her I started to get someone, I think maybe gonna no started to be a good person to me. I’m sorry…

R2: No, it’s fine this is your time we are happy to hear what you have to say. Thanks for that, thank you. Did you do any individual therapy like one to one therapy, you did group, did you do group therapy?

Q: No

R2: You did the one to one just between you and Catherine

Q: Yeah yes please

R2: OK so I think I may have asked that question it says how did you feel about it but you sort of said isn’t it

Q: I like to talk to like I told you before one by one my problem before because I told you I was not trust people and I think maybe when I talk with another people I don’t know maybe so…

R2: Ok ok and you didn’t do any group therapy where there was other patients with you in the room?

Q: No

R2: No you didn’t ok. How did your feelings about yourself change over the course of the therapy, while you were having the therapy, how did your feelings change?

Q: That I told that in my life has changed a lot because now I have people close to me, I close to people I talk to people nicely, I started to love people, to trust people because before I was not trust anyone. I think maybe it’s the same person maybe it was in my mind I was thinking always like that, anybody who come to me gonna kill me I was always think that. But now when I see people they come they didn’t do nothing to me I say oh Jesus Christ really yeah I started to be oh maybe if I was maybe run away because before I was run away to catch my back run away and I saw people following me gonna kill me run away something told me in my mind (name) run run people gonna kill you. I look at I saw they coming to kill me but a person like that and you see now I started even to be with cross people absolutely, I am so happy and I appreciate I don’t know how I said thank you. Absolutely I am so happy I am so happy I don’t know really I don’t know because {crying hard to hear} I’m sorry because I was remember my past when I was and I feel I something told me jump jump like a ?? and something told me jump they are coming this way, open the window and jump, and when I see the train I run like maybe when I got something, when I
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see the train something told me jump jump and it never said when you jump you gonna die this said no you are not gonna die when the train comes you gonna lie down the train it go and you gonna hide there and nobody gonna see they coming that person who like that it really situation no I catch my back and go for shopping, I do everything I not feel fear, so I feel absolutely amazing amazing thank you very much amazing.

R2: I’m really happy to hear that, so you definitely say your feelings have improved?

Q: Yeah improved a lot. I am not crying because sad, because I am happy.

R2: oh ok

Q: I am happy because my life is back. I was a strong woman before stronger woman in my life absolutely everybody say wow you like a man. I saw what who come to me like that, my life gone down down it started to run away. That’s why now my life is back I am so happy, I cried tears of happiness not sad but tears of happiness yes

R2: It’s fine, it’s fine. Ok, how did your feelings about other people change over the course of the therapy?

Q: Yeah if there is people like me when I was on that situation really really and they got the support like that I think will help a lot maybe there is another people suffer like me, if I didn’t get that support or like absolutely was die completely die, because I was going to kill myself, maybe because something told me jump now. When I think I say if I jump I was already die I know now when I say I say oh Jesus Christ so before I was not think when I jump I gonna die so words like that something was already oh it’s a difficult time, I am sorry.

R2: Are you ok?

Q: Yeah, I am ok because that’s why that time was a difficult time, so yeah, but I am ok now I am good I am happy really am happy really am very, very happy thank you very much.

R2: So you would say that your feelings about other people have changed now, you would say that

Q: Yes

R2: How do you think that the therapy contributed to the change, how did the therapy make that change?

Q: I think to ask someone if I think to ask, if you talk with someone and they tell you everything, I thinks it’s help because oh Jesus I don’t know how to explain. I think therapy to talk to someone, that person had the problem like my problem before… I think when you tell them and you get more like a,, I don’t know like advice I don’t know what they call it because if you tell someone and like when I talked I was talked to her and she told me, like I don’t know what they call it I am so sorry
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R2: No it’s fine

Q: Because I was spoke to her and I tell her everything what was happening to me and I don’t know what to explain.

R2: No, you are doing well. You are doing well. What other things have helped you when you were feeling bad not the therapy itself but for example sport, work, social activity, friends, family, yoga, meditation, gardening. Is there other things that helped other then the therapy for you like for example doing a sport, going to the gym, listening to music, cooking perhaps did these things help?

Q: No

R2: Meeting up with friends or

Q: OK to meet ok it helped because when you meet sometime when you meet with a people sometimes you forget their problem. You meet with people you forget that problem some people they forget and when you back home it started back, when you like go to gym you if you don’t get another some person to talk to, to help maybe have experience with that, and just you say because if I had that problem before and I didn’t come to Miss Catherine, I’m sorry to call Miss Catherine Dr Catherine, but and I said let me go to gym when I back home is come again when I because I was at that time I went to college, and when I went I was there sometimes when I forget a little bit but when I was walk to home back again I go to bed I got home back again, that’s why you need to go to that ok when you go to maybe to another places, and you need someone who help to spoke to and to help you your problem, just even like a non medication now I see now, but when you talk someone I think really, really it help a lot yes.

R2: So would you say that the therapy was the main thing that helped, nothing else helped like the things that I just mentioned?

Q: It’s help if you have I think all together is working together yes.

R2: oh ok

Q: because if you get support from therapy and you go to gym. When you go to gym because therapy already told you you spoke to therapy you go to gym you be strong you don’t think that you enjoy the music, when you come back you started because you already got the support from someone I think it’s more improved yeah more improved. But I think it’s the main person therapy therapy more I think is the more it’s like the roots, it’s the first person because therapy talk to therapy and you go to gym because you already talk to therapist you can go to gym because you already talked to if you not talk to her your cannot go to gym because you don’t trust anybody you think in the gym they gonna hurt you gym they gonna meet bad people you can’t go to enjoy if any like a party because you see when I go to party there is some people gonna hurt me. I think therapy because you already talk to therapist that’s why because I was talked and now I started to join people. I can go to church nobody can touch me
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because I already spoke to her. I got a job nobody hurt me because I was spoke to her, she already support me yes.

R2: So you mentioned the gym, was the gym something you enjoyed doing when you were doing the therapy did it help?

Q: Yes.

R2: It did help

Q: Yes because if you not you have to go yourself everybody go to gym you can’t I tell you the truth you can’t go even I was scared to go outside how can I go to gym. Even to fear to go outside to buy my food and I stay all day the house watching outside who is standing there, how can I go to gym because I first with her I spoke to her I got more strength it’s called strength more strong I started to more open my brain, I said oh let me try what she told me let me try to see if something gonna happen let me try to go to shop to see if I go nothing happened and let me try to go to gym and nothing can happen I started to enjoy. But it’s working together but the main person is someone who support you. Yes you can’t go yourself decide yourself let me go to gym no no and you have to need maybe some support to push you to tell you to explain, to advise you to make you strong like someone who crossed and who know your people because when you talk what I find with her I feel I spoke with someone who my best friend someone I trust and I open all what was happened to me and I open. I tell her everything about me and I no fear, no scared I was trusting her and it helped me because another person, I was not talk to another person like that I was scared this person maybe it’s this person maybe it’s with that people maybe it’s the same group with that people, but when I was spoke to her I feel I open and I feel la release, it’s called a release.

R2: OK, that’s good to hear. How has your life in general changed since therapy ended, probably answered this before, but how has your life changed since you finished the therapy?

Q: Yeah I started to change I thought yesterday to change when I finished with her. I was still with her when I started to change to change that’s why I said I said let me try, maybe this voice is a liar, let me try maybe this voice come in my head was let me try I started to see more improvement more more more and now I am ok, I am free absolutely I am free walk on the street, I am not like this before I was like this every time I feel someone is on my back. Now I walk yeah I am so happy really.

R2: That’s good to hear. I think we are finished with all the questions, there is 5 minutes remaining, do you think we have missed anything is there anything more that you would like to talk about?

Q: Me, I think I am already talk to everything

R2: Then I’d just like to thank you for coming today and making that contribution. If you want a summary of our discussion today then you can contact Catherine, this is her e-mail details I think it’s in here somewhere if you
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would like a summary of the report. So any other questions that you would like to ask?

Q: No, I am ok

R2: OK then I would just like to thank you again for coming and taking part in the research, thank you very much, thanks.
CM: So welcome today everyone and thank you very much for coming, I hope you did all get the transcripts. The point of today is very straightforward: it's just to make sure that you tell me what themes you thought were most important, what things you thought were most frequently mentioned, and the third question: How did you feel about doing it all? Did you think it was a good idea, how did you feel talking to the participants, how did it change your view about yourself, what did you think about research, there's probably loads of things I haven't thought of. There was quite a lot to read though wasn't there? r3: It made good bed time reading!
CM: Really?
r3: Yeah, seriously yeh
CM: So (r6) will be along in 10 minutes or so I think but there might be quite a bit to get through actually. So I wrote the questions up there and we might also write down people's points as well although I'm also recording to make sure I don't miss anything.
r3: without the ums and the ahs (laughs)
CM: I know
R1: One of the things I found interesting was the people who had suffered war trauma or that sort of thing, cos I've never met anyone, I mean yes you see it on television but I've never met anyone you know.
CM: so you interviewed 2 Sri Lankans was it?
r1: Yeh and then the young girl and um the gentleman from Congo.
CM: Yeh there's another patient from Congo who's a man who spoke to r1 and participant O is from London isn't she?
r1: yess. Springing sprightly O...
CM: Obviously you did know peoples real names but you must remember that that's really confidential and you should just forget them straight away. I mean we might use them this afternoon but never again.
r1: We'll have no need.
CM: No, that's right, probably not. And if I talk about them in the published study, I'll make up a name. And for you as well, so that you won't know unless you know who it is. So you saw that I already gave you just numbers researcher 1,2, 3,4,5,6,7, just according to the order in which you got in touch with me.
R3: Why was r4 blank?
CM: Because she came to the first session of training and so I might talk about her. I don't know, you know, the reasons why she might not have come, she didn't actually tell me, it would just be speculation on my part. And then the participants I just did them in the order you interviewed them, A B C D...but when it comes to writing about them, I probably would give them a name because if you give somebody a number or a letter, it's a bit impersonal. And sometimes I would also change some details, so I wouldn't say which country they came from or anything else about them.
R3: Why was r4 blank?
CM: No identifiers
R3: Can I ask you a question, it's been bothering me for a few weeks now and I can't seem to, I think it might impact on what we're discussing later. When you were thinking about, planning the research, do you have the stats of the people
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you asked to participate in relation to those who actually said yes? Like, did you ask 100 people and only 20 said yes?
CM: I have got it somewhere but I would have to work it out. I think what I did was I did it in batches, so I did it in chronological order so there was the first 20 people who were eligible and then I saw who responded and then I would go for the next 20 people. So doing it like that meant that we didn't send out too many different requests and there had to be some things that you had to fulfil, so you had to have finished therapy, you had to be relatively Ok, supposed to be not working, I can't remember the other things..but there was also another underlying criteria like did I think it would be a good idea? So did I think it would be interesting for you? Would some people quite like to do it? Cos some of you had said things like, oh if I can do some volunteering or oh, I'm interested in the treatment, some of you had said that to us so.. yeh. Anything else that you were wondering about? are these good questions to ask?
r3: I think the points people made about their treatment, that's going to depend on what treatment they had isn't it, cos some people were more positive about some types of treatment than others, so the questions doesn't really expand enough, but maybe it will when we start talking about it.
CM: Yeah, but the reason for asking you is that as a professional, I can look at all the transcripts and select the points myself. But it's actually quite important (r6 enters the room, hi, hi,) Welcome, you didn't get wet did you.
r6:no no
CM: I was just saying that one of the reasons for having you all here is to make sure it's not just my ideas that are prominent in the study but that all of you who also have got the experience of doing it, have a sort of formative influence in the themes I choose to write about. I had written up some very broad themes there...so everyone got their own transcript and everyone got the interviews they did with other people, which meant that some people got quite a few. But you didn't have to read them, it was totally optional, you can talk from memory if you want. But the other thing I did was, I sent all the transcripts to the people you interviewed and asked them whether they wanted to make any additional comments, because I was told I had to do that by the committee that approved the study. They said, say people don't have enough time to make their comments, you have to give them an opportunity afterwards to write and say something else.
r1: Did anyone?
CM: Well I only sent them out this week.
r1: OK
CM: I don't know yet, do you think they might?
r1: Yeah, a couple will.
r6: Especially the last person I had. Well, I think all of them probably want to say something, most of it positive.
CM: Ok so just thinking about the transcripts, what did you think were the most important things that came through to you?
r2: Time.
CM: Time? not enough time?
r2: Not enough time..mm.
CM: Would it help if I write it up there?
r7: It's ok
CM: It's ok to just talk? Which do people prefer?
r6: I don't have my glasses on so I can't actually see most of that (laughs)
r7: Don't mind.
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r1: Whichever you choose.
r3: don't mind
CM: You can't read it anyway (to r5 who has just had cataract op, everyone laughs)
r5: Cover one eye, no, no it's OK but it's moving, I think I drink too much (laughs again) No it's OK.
CM: All right, well, maybe we should just go round. So first one was, people were glad they had the therapy, then r2 says too short, r3, what stood out for you?
r3: Aftercare...
r6: Yeah, longer was the main thing for most of them.
CM: What was your feeling (to r5) about the most important thing?
r5: I think it was good idea to comment about these things today because when you had the interview you feel a little bit nervous or maybe... sometime you are OK today but tomorrow you don't feel great yes? Ah, with this opportunity if I look something I forget or I like to remark, I can do it yes and that is good because I have a chance.
CM: More than one. mmm (to r7) What did you think was most important?
r7: Confidence. When I talk to people about interview it was not the most important thing in therapy for most of the people I talk to, before they start therapy they were keeping on their mind the thing they was facing but when they are confident or they trust someone they can talk to, with talking they can be confident and they tell me it's very, very important.
CM: You mean the length of time they...
r7: The length of time, yah yah very important.
CM: And how did you feel doing your last interview?
r7: I can say it's make me remember, because someone coming from the same country as me, a lot of things I knew before but because the part she was coming from, I know a lot of things, the people talk about that part of my country, someone who comes there, I realise the thing I was facing myself, there are many people who are facing the same, on the same level as me, and I can say after the interview, I face a lot of things, a lot of problems in my life, and when you interview someone it's like you give advice, you are support someone and you are down, it has helped me a lot.
CM: Good mm. Did anyone else find that? You were saying something like, if you are doing the interview, it puts you in a different position, (r7: yah yah yah) and it makes you feel different to being interviewed, something like that?
r1: I kind of felt as you were saying just now, you know as you said, feeling different, in a way I felt, who the hell am I asking these people these questions, you know, I'm no better than them, you know. I didn't want to come across that I was in any way I don't know... the point is, what I'm trying to say is, I wanted them to know that I was just as they are, I'd gone through my own stuff and I didn't want them to feel nervous in speaking to me so I made a point of making sure, I said it several times that I was a service user and so forth and so forth. I didn't want them to think: Oh, someone's judging me, asking me these questions.
r2: Yeh, just what r1's saying, being the interviewer, like puts us in a position of responsibility which probably helps us as people as well because it makes us feel... not completely recovered but we've gone some way towards recovery... and um maybe subconsciously or in a placebo way, I'm not sure, yeh, it takes us a step further in terms of our recovery to see how far we've come,
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that the role is reversed, yeh. So it's good that we were put in this position I think, yeh.
CM: It sounded from the interviews as if you really enjoyed it when you were doing it.
r2: I was very nervous (laughs) but something about the first question, the other important thing was the relationship with the therapist, that came out.
r3: Yes, very much so.
CM: the relationship with the therapist.
r5: I think when we have the interview, we talk just like one person to the other, and I think only people feel a little nervous. But like this, we talk we comment openly yes? That is better because you feel relaxed, you can think properly. If not you need to focus something, it's different. That is why I say like this more comments, different thing, that is good because it's a compliment what we say before.
CM: Yeh. What about r3 and r6?
r3: I just, I was saying to r2 on the way down funnily enough, I've been very, very surprised by doing this that my opinions of how I felt about the therapy and how it worked for me, has changed because of this. Very, very strange. I'm now far more positive about it, than I was before. So I've gained something from it which I'm really grateful for actually, yeh. It's more confidence I think and realising that some of the things that you thought weren't useful, weren't good, when you actually sit back and think about it now, I actually realise what the point of it was at times, it's a bit deep, heavy, but I start to realise some of the therapy was yeh better than my interpretation, and that's been very, very useful to me. And you know, listening to people, reading the transcripts, particularly I got the feeling that all those I was involved with in interviews had far more positive feedback on the therapy than I expected. so that was a bit of a surprise actually, yeh.
CM: It was a surprise to me as well.
r3: Mm, really.. really good, yeh.
r2: Was it all positive?
CM: No, but most people were positive...it was also interesting that they seemed to feel like they were doing something good for other people by coming in to give their view, so it was a bit like they had some responsibility as well to come and talk about it to talk about other people who were going to be like them so...you were the stage further on, but they've felt a bit further on than everybody else, and I had not anticipated that and I thought that was really good (r3: it was yeh) especially for some people who had finished quite recently, being asked to come in and say what they thought about it in an interview, they really...but I don't know if only the people who felt positive agreed to come?
r3: That's why I asked you about how many people did you, you know, have, and how many agreed to be interviewed because I think it's an important issue.
CM: Well, I will do the statistics eventually.
r2: I would feel more inclined to come if I had an issue with the therapy
CM: to complain?
r2: To complain, (laughs) yes.
r3: That's a very good point actually.
r2: If it worked, I might just be getting on with my life and I don't know whether I would, I may or I may not have come in but...
CM: Well, there was one guy who r6 interviewed who I knew was going to be negative... What was your feeling about it all (to r6)
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r6: Overall, or about that one guy?
CM: Both. Overall first I think.

r6: My experiences of it..um..yeah, kind of similar to what r2 said about the position of responsibility and even though I thought I wasn't as far ahead as I thought I was, sitting in the room and being there showing up, doing it, kind of showed me actually yeah, we can do stuff instead of staying in our own little bubble. so yeh it was quite nice that. Yeh it was good to see everyone else's perspectives of what they've been through, what they've done and what they've experienced and it kind of gave me more empathy for everybody, and for myself as well. Overall, for me I thought it was a really good experience, yup, really enjoyed it. Glad to be a part of it. But yeh, that last person, I think maybe he...I don't know if he wasn't in the right place to do it but it felt like he..it wasn't positive for him, I think maybe it wasn't the right sort of therapy that he needed, I can't remember if he had the one-to-one or if he had the group therapy.
CM: He had one-to-one...we did have a men's group quite a long time ago, that only one person had been to I think, in 2015 maybe. But then the Sri Lankan men had all been in a group, but you know what really interested me about that and about quite a few of the interviews, that I would be sitting there listening to all this talk and it sounded like everyone would be having great fun and it would be for a long time, and I'd be thinking, oh it's 10 to 4, you know what's going on. And then one of you would come out and say, Ok here's the interview, it's 12 minutes long! (everyone laughs). And I'd think, what happened there so people were obviously talking to each other but they didn't want it to be recorded.

r6: I must admit for that last one, I think I had about a half hour conversation with him, same with (participant L), someone else as well sorry, and yeh, I think it was like r1 said about explaining who you were a little bit more, a lot of them wanted to know who I was, and asked if I was a therapist or a service user so I kind of discussed that a little bit and I think yeh, that kind of went on, and then we all went into our little stories a little bit, shared a bit more before we actually did the interviews. But I think that helped a lot of them, put them at ease, especially the first person that I did, the first lady that I had. And then the last two, I think.
CM: Did everyone find that, did you all have a conversation before?

r7: Yeh, a little bit we had a conversation before
CM: In French or in English?

r7: It was French (everyone laughs). I ask if we can do the interview in French, she said said no, English is very fine.
CM: Oh I see.

r1: There was one gentleman, as I say I always tell them in the beginning what's going on and so forth, and who I was and he started to get really interested, like off-piste, and I thought do you mind if I record that, then he went on for 15 minutes.
CM: Ok yes, that was interesting cos he was talking about how in Congo there's isn't any mental health service and how he's really pleased to be in England because of that, and he wouldn't have got the right help, and church provides one kind of help but NHS provides a different kind of help, is that him?

r1: Yes yes.
CM: Yeh, that was good that you did that, that's on the transcript isn't it. So you all had to..

r3: One of the ones that I did, he was almost in tears at the start, took a bit of reassuring before the actual interview started, and he started telling me personal things which obviously wasn't the point of it, and we sat chatting for
about 10, 15 minutes before, because he didn't want it recorded for obvious reasons and I told him because I had some experience of what this person was saying, not personal, through family, I was able to identify with something so you know what I'm talking about.

CM: Yes

r3: And that was very reassuring to him so when the interview started, he then it was almost sticking to the script, that he wouldn't allow the first bit to be on tape and I understood why.

CM: Oh ok.

r3: Yeh so that's why that one took a bit of time actually.

CM: That sounds like it was hard work for you.

r3: No. No it wasn't difficult at all, I think because I had an understanding of what he was talking about that I found it easy actually. I thought it was easy and he felt more confident about responding, so it did work. I wanted to give him a hug (laughs)

r5: It is good yes.

CM: Did other people feel like that?

(several answered yes)

CM: Or just lots of fellow feeling?

r1: There was one fellow, he looked at me as he came in the room, that was the only time he looked at me, he never looked, he was everywhere you know. he was just in so much pain, I could feel the pins and needles in my solar plexus and I could actually feel it pulling out. I wanted to, I wanted to cry for him you know? he was just he was almost in a trance.

CM: I don't know why he was in such a state. I mean it is somebody who doesn't have his visa so he's got no Leave to Remain, and he did work here for quite some time and did well, and then one day he was driving down the road and the police saw that his light wasn't working. and they discovered that his visa...but what did you mean when you said it was different, people who have had a problem in war?

r1: Because, in our group that we had in here, with us lot, you know, r6 and.. CM: The women's group you mean?

r1: Yeh yeh, we talk about certain things and naively part of me thought that was what all this trauma was about, that you were helping.

CM: Oh.

r1: I never thought about the war, you know, I never thought beyond...the type of trauma that we had gone through. But because I know the type of trauma that happened to other people happened to us happened to other people, but I never thought, I've never experienced talking to somebody about war, what war does to you, and battles and that sort of thing, and it's a completely different energy, it really is. you may not thing so, but it is.

CM: Oh I do think so, yeh.

r1: It's a completely different energy and I thought in a way I felt that they were being ravaged by tigers, that's how the energy came across to me. You know, like in an arena where there are slaves and they're thrown to the lions and the lions and then somehow they escape. That's how it felt like to me, that sort of ravishing.

r5: Mm that means all the question we write to ask other people is very straight because maybe the other person take out all the feeling, that's why you feel all this, because when you talk with other people, the people have the view of what happened before and try to describe this experience never seen before.
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r1: It's nothing that I'd ever you know...yes, you can hear something but it doesn't, somehow doesn't relate to you, you can feel empathy for them but you don't feel for them in that way. But as soon as you hear them speaking about their...that sort of trauma, it's something else.
r5: I suppose because the people give, give because they need to give, the reason for the interview to take out and when you receive all this like (makes shooting gesture and sound) and you feel inside.
r1: Part of me wanted to ask all the questions that weren't on the sheet, all about their experiences in Congo or wherever it was, but I know that's not what we were there for. But it was so new to me I just wanted to delve and go into it.
r2: Can I just ask what r1 sort of mentioned earlier: Is trauma trauma, whatever the experiences? Or is it like...
CM: Well I was going to ask you that. (everyone laughs)
r2: I don't know, well, people who have been through a war or natural disaster, is it the same as somebody who's had a childhood trauma perhaps or is it the same symptoms, all the symptoms felt with the same intensity or does it just depend on the person?
CM: That's a good question...umm, and there isn't a straightforward answer, but what's common to both of them usually is the trauma that's been inflicted is inflicted by other people. OK and so that means that it's difficult for people who have had those experiences to then be in the world with other people, given that it was other people who inflicted that trauma in the first place.
r5: I suppose, if you are a child, it's different from if you're a grown up man, it's different. And another thing, the environment you have got around. If you are young a boy, you need to be strong you try to be strong, it's different, but I think the traumatic experience it's the same in one way or another if you put between 1 to 10, both is 9. It's not that one is bigger than another. Because...
CM: Well, except for what we would distinguish, isn't between those kinds of trauma but between something like having a car accident. So if you have a car accident it doesn't involve another person, and it might be easier to help, and so that kind of problem, trauma, we would called 'simple 'PTSD, but the more complicated kinds are where it's been done by somebody else.
r2: Does it depend as well what stage in life you are, as a child there's a lot of needs, emotional and intellectual I think.
CM: So r5 is saying, as a child it's different so if as a child you have a lot of family support, it'll make it easier for you to cope if something goes wrong.
r5: Because when you are a child, you don't have no-one say that is bad, that is good because you can't think properly, you need to grow up a little bit, have experience, and so you take this thing as a normal thing yes. But later you have the problem because then you realise that is wrong, I suppose it's different.
CM: Yes. but you're right that most of the people that Avril and I work with, have had either early traumatic experiences or wartime. And that's the reason for the new diagnosis 'complex PTSD', and we thing it's quite a good thing because then they won't just start doing CBT and saying , not that I think CBT is always bad you know, just go through this quickly and then you'll be Ok after 12 sessions, because probably you' won't .
r1: I've been watching the news bulletins, all the actual footage of these women and children in Syria, running with their children and bombs are dropping, and you know, I started to think more about war trauma, I can just imagine what they're going through now.
r2: Would a new type of therapy come about with this new diagnosis, would it like be a complete restructuring of ..
CM: No not completely new, but what they'll be thinking about is, what kinds of things do we have already that might work, which is the reason why you were asking the questions you were. So you were asking people which did they think was better, the group or individual? EMDR or exposure, or just talking and having a relationship? But of course we could only really talk to 24 people so what it'll do is give other people ideas to follow up really. Did you think there could be any new treatment or...

r3: Approach..approach to it as opposed to treatment, amalgamate some of them.
CM: Well which bits would you say should be in and out?

r3: I think some things I haven't changed my mind on (laughs) and that's aftercare, aftercare and having something like, I keep spouting about MIND because I think they're different, being able to work in tandem. so if you've got complex trauma, more than one site of the trauma or..then what you experience in therapy is not necessarily going to help with all the complexities of it. So if you have another thing outside like you do volunteering and things like that. So it's in some ways therapeutic to you as well as you helping other people (r5: yeah) And I think a lot more, maybe with this a lot more should be done to try and get these people even while they're going through therapy to start something like that as well because when the therapy stops poof, that's it. And it's my biggest bugbear with it because it's just like, don't worry, if you start feeling bad again, go to your GP and they'll do a referral. Some people, it's taken years for them to go to their GP and you're saying well, go back to it. If you're going to, as it is now, they're bringing out this complex trauma, then deal with the complex trauma but don't just do it as a therapy in a room or a one-to-one, expand people's opportunity to help themselves a bit more. I feel very, very strongly about that.

r5: Like before when we had Carmine [peer support worker in the team] yes, we finish the therapy with you and then we pass to Carmine and we help each other and we start to, and it's very, very good because we have one leader, if we like to know something, we can ask straightaway or he can give a choice, do you want to do this or this? And after therapy has finished that is a bigger step because you are in one way alone ,but with another group, you are never alone yes. Because we know

r1: I remember in the beginning of the group therapy, I had so much rage in me, I could have beaten a baby with a cricket bat to death, that sort of rage. Not that I'd ever do it, but you get my meaning, and I never got the chance to get rid of the rage. I would have like to have a sledge hammer that I could handle and demolish half of this building just to get the rage out you know, and I don't know, sometimes I don't even know how to transform the rage. I bury it.
CM: So just thinking about those groups that are being mentioned now, would that have been any use to you? I know you tried the art group but...you weren't really in the right place (r1:No) did anyone else
r1: No, you have to be in the right place to do anything.
CM to r3: did you go to any of them?

r3: Yep, that's why I'm saying about them. I preferred the social one which was on the Friday at the Crypt.

r1: Oh yes, I've seen that, what did you think of it.

r3: It was brilliant, I haven't been for a long time now but it was brilliant. You went, it was between half four and seven, you had a spread out, tea, coffee,
juice, there were people recovering or recovered, recovering I think is the right term, of helpers there and everybody that wanted to, you'd go, you'd have a chat, you could play cards, you could play music, you could just sit and chat.

r1: I always imagined it being, the image in my mind about? I never went. All I could see in my head was, you know in an asylum, there are people just walking around like this, with their heads down, no-one's speaking to anybody else, just looking at each other, that's kind of what I imagined, I really did.

r3: No, there was laughter, joking, (r1: I never expected..) we even went to the pub a couple of times after, you know, as the group, we went and had a beer, two beers, went home. And it just lifted you, if you know what I mean. It was very rare that people talked about their problems, their issues.

r1: I thought about it so many times, never went, not even once.
CM: so this is saying something like help with building a social network, something like that.

r3: Absolutely, give people confidence to meet new people and interact with people which you don't get so much when you're in therapy because as we know you're discouraged from getting too close to each other during therapy, I don't know if that's going to change or not, it would be good if it did. But you know you come out of the therapy session, and that's it for another week, or fortnight or whatever it is. At least if you had something like MIND or a group that you could go to as well, then one is helping with the other.

r1: For myself I remember when the group finished and I was at home and about the third week, it almost felt like I was on a desert island seriously.
CM: What about the people you spoke to, do you think they got anything out of groups, or attending any?

r1: They did, they did get a lot but as everyone was saying, it's almost like the rug being pulled from under you, what now, you know, some of them. One or two of them who was doing the garden project, he liked that and that helped a lot, and the young girl who I saw she was better than anyone else that's all I can say, but she was grounded in her family whereas everyone else wasn't.
CM: Yeh, she had kids didn't she.

r1: Yeah and partner and mother and all the rest of it. I mean I'm sure everyone has a mother, what I mean is, she had good relations with hers and that was helping her. But everyone else, it's almost as if OK now this is over, what now?
CM: What about your people (r6)? did any of them talk about the significance of groups or a social network or the community? Some people talked about church didn't they?

r6: I'm just trying to remember, I've got a feeling that it was good for some, but I think a lot of people found it difficult to attend the sessions anyway. So as much as I think it's a good idea to have the social, maybe something that might be less pressured for some people, cos sometimes attending, just doing the basics, showing up was difficult, and as much as the social thing and combatting the isolation is needed, being in a group setting is not always good for everybody. I don't know if it's possible to do something online, like an online forum, discussion, chatroom, I don't know. But I think finding different things for different people. Cos like (r1) said with the anger, I think some people might have anger issues and them being in a social situation might not be the best thing for that person at a certain time. And then as much as they want the connection with people,
CM: Is it good to do other things, you know like to have a different focus for the group? Like art or gardening rather..
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r6: Yeh I think so, I remember you guys said something when we had the group about other things that were going on here but that was towards the end, and to be honest, I know I didn't take anything up. But I think that would have been good incorporated in what we were doing so maybe if you have a session once a week or twice a week, one of those sessions a month is dedicated to something else to try and get you out of your shell and you might have to experiment with different things, but everyone's different. Some people are quite visual, tactile, some people are quite chatty, some people...you know it's complicated trying to find something for everyone..
CM: Well I was just thinking about how limited we are actually..

r5: You know you say about religion of the Church yes, I grown up in the Catholic church but I no believe too much in God. But I found in the church friends, yes. And I take it as a family because in general the 80 per cent of the people is really nice, yes, and especially in this church, after the church you have coffee, tortilla, some cake, we talk about the garden, we talk about different things yes for one hour yes sometimes for two hours, and ...it's different because I am foreign yes, but in this way I integrate more and I felt more better.
CM: I think what you're saying is that a way to integrate into the community but not necessarily religious. (to r7) You find church useful as well don't you? do you see those people outside church?

r7: Yeah yeah, friends, I have some 2 or 3 friends outside church...
CM: And the person you interviewed she talked about Islam didn't she?

r7: Yeh yeah she was a Muslim.
CM: she talked about praying...did she go to mosque?

r7: Yeh yeah. I have one friend...
CM: I suppose I'm wondering could our department make more links, we have some links with the church, we don't have very many though with other places like the mosque really.

r6: I was just thinking about other spiritual things, I mean with the different exercises that you used to give us, there was meditation, safe place, it might have been quite nice to have a place or some time to practise it, cos if I'm honest I don't do it very often. I need it but I don't do it, and I think if I'm with a group or in a place, again something, something that's once a week or even before the session, half an hour you're doing just meditation, just practising you know, doing something like that, I definitely think a spiritual thing obviously with religion but also on a sort of meditation kind of thing might be helpful cos you gave us crystals as well at the end of it. that would be nice to do something with those, learn how to use those properly.
CM: Mm. did many of the people you spoke to, talk about religion?

r1: Only one in my case.

r7: One about Islam
CM: One Islam, one Christian, not really.

r2: Mine didn't speak about religion but she kept praising God and thanking Jesus so I'm assuming she is very...
CM: Yes she goes to church...

r1: But do you know I must say, I thank God and do all these things, but I don't go to church, I never go to church, and if somebody invite me to church, I'll make the biggest excuse not to go.

r6: That's why I said the spiritual thing about meditation
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r1: Even though when this thing the group had finished, I thought about going...no pastor would want me in their church, I'm not a quiet sit-and-listen type of person.
CM: But I think (r5) would disagree with you because the St Mary's Church is very welcoming and has all sorts of different people..
r1: Yeh I have to admit when I did that what do you call it fair with C. [peer support worker], it was last year, that's what I found. A lot of them were...it was more like a social place more than a church. It wasn't very religious. And also I liked the pastor because he was a bit of a maverick you know and I...when I stood there that day at the fair helping out, a lot of people were saying to me Oh, you should come to the church. I can just imagine see me up in the pulpit saying what a load of shit (others laugh). That's the sort of person...you know, that's why I don't go. This thing in me wants to say: shut up!
r5: But that is, maybe you are afraid about..
r1: No, no, no
r5: Afraid about yourself, going to be difficult
r1: in this setting you mean? I could be, I could be afraid but I don't feel that I'm afraid. I feel that I'm annoyed.
r5: You feel angry with...inside, still a little bit, that is why
r1: No, my anger is the mindless prattle that comes out of a pastor's mouth, that's what my anger is. I'm sorry (r7) because of church...
r7: No, it's OK, it's OK.
r3: I live right opposite one...every Sunday whether I like it or not.
r1: There's 4 churches within walking distance of me. When I say walking distance I mean 10-15 minutes, four churches.
CM: I think it's important though to distinguish between the church as a community and..
r1: The religious part of church (everyone says yeh, yeh). If the church was more of a sort of community sort of place, I would perhaps visit more often.
CM: Or the mosque for that matter actually...which does have a lot of social activities.
r2: Yeh they do, I think some people they want to be part of that community, maybe sometimes it's less about the faith sometimes and it's more about being a part of something, and that's more important for some people. I think religion can help as well, it gives like (r1 consolation) yeh, yeh definitely and it adds another dimension and another reality and something additional.
r1: I don't mind community-oriented church but not many churches are community-orientated. They give it lip service some of the time. I saw a film the other day about church, it was very funny and I thought to myself church today would never do that. I mean he got himself in trouble being so open to everybody, it was a Peter Sellers job, you know what Peter Sellers was like. But I thought to myself it was a good idea, but at the same time I saw the hypocrites. Anyway...
CM: Yeah I think there's a lot of different ideas about it. I tell you what, shall we have a 5 minute comfort break (r3 cigarette break, some things don't change)
r5: Smoking break, ha ha.
r3: I've timed it, a minute down, a minute up and 3 minutes to smoke (laughs)
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APPENDIX M. Interview Schedule Questions
Briefing for researchers, with questions

Study title: What are patient views on psychological therapy for the new diagnosis of Complex Post-traumatic Stress Disorder, CPTSD, based on interviews by service user researchers with 24 former patients in the London borough of Lewisham?

The purpose of the questions is to find out what patients thought of their psychotherapy and whether there were other ways of helping themselves get better, such as social support, working, sport, music, religion

Location & equipment: Ladywell Unit- Catherine will sort out the room. Recorders will be given to researchers beforehand and should be handed in afterwards. If you have questions before or after the interview, please ask Jo or Caroline in the Admin Office on the 4th floor if Catherine is not available. Please hand in the recorder and the consent forms after the interview.

SUGGESTED INTRODUCTION
Welcome to the interview today and thank you for coming. My name is XY and I’m a service user researcher here at the Ladywell Unit. We’ve invited you today because we want to know how you feel about the psychotherapy you had here. We really want to know your thoughts and opinions about it because the NHS has to decide what kind of treatment is useful for people who have symptoms like you had of PTSD. I just want to check that you received the Information Sheet about the study. (If not, give another one, with time to read.)

There are no right or wrong answers; we’re just interested in your point of view. I want to emphasise here that we don’t want you to go into the details of your personal story because that might be upsetting for you. I just want to hear how you felt about the therapy you did.
Before we start, I need your permission to tape-record the session because we don’t want to miss anything you say. It’ll be passed to one of our psychotherapists, Catherine Matheson, to transcribe afterwards. If you agree, could you read this consent form and put your initials in the boxes and sign fully at the bottom please? (sign 2 consent forms, give them to client to sign and take one back. The other is for the client.) Catherine may use the information for her studies as she is doing a clinical doctorate, and this will be anonymous. Also, if anything is published by Catherine, there won’t be any names or identifiable details attached to comments and so you can be assured of confidentiality.

Is there anything you want to ask before we start?

QUESTIONS:

How would you describe how you are at the moment in terms of your emotional health?

What about your relationships with other people- how would you describe them?
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What did you feel about the techniques you were taught to feel more stable, such as grounding to keep you in the present, breathing or sleep hygiene, or the Safe Place?

Which techniques, if any, do you still use, and why do you find them helpful?

How did you feel about talking about your traumatic experiences in therapy? Do you think it was useful to focus on trauma? If not, why not?

If you did any individual therapy, how did you feel about it?

If you did EMDR, how did you feel about it? What was helpful/not helpful?

If you were in a group, how did you feel about it? What was helpful, not helpful?

If you did Narrative Exposure Therapy (with stones and flowers on a timeline at the beginning), how did you feel about it? What was helpful/not helpful?

How did your feelings about yourself change over the course of therapy?

How did your feelings about other people change over the course of therapy? How did therapy contribute to this change?

What other things helped you when you were feeling bad—sport, work, social activities, friends, family, yoga, meditation, gardening are some that people have talked about?

How has your life in general changed since therapy ended?

ENDING:
5 minutes before the end…

We’ve now got 5 minutes before we have to finish today… Is there anything we’ve missed out?

I’d like to thank you very much for coming today and for the contributions you’ve made. If you want a summary of the report, you can contact Catherine to ask for it (contact details below.) Are there any questions? Then I’d just like to thank you again for coming today and helping with this research.

Contacts details:
Catherine Matheson
c.matheson@nhs.net
PATIENT VIEWS ON THERAPY FOR CPTSD

APPENDIX N. NVivo coding showing extracts under the node “Trust”.

Files\participant interviews\Interview by 1 with D(4)
I reference coded, 3.86% coverage
Reference 1: 3.86% coverage
you are gonna think about trust, confidentiality you know yeah so I’d say for the first couple of sessions it was really hard but then afterwards I engaged my mind thinking I’m here because I want to get help so unless I participate and put something in I’m not gonna get anything out so I just opened up talked about it

Files\participant interviews\Interview by 6 with C,(6)
2 references coded, 1.57% coverage
Reference 1: 0.81% coverage
once you gain that assurance, is it assurance, when you know it is just between like now me and the doctor only it gives me confidence and after a while it gives me the trust to that person to the doctor and once I have it I feel I will be able to… everything
Reference 2: 0.76% coverage
now I have all that trust in her, I have that, I don’t know how to put it I feel like I can ask her anything and with that I think it helps when the doctor is the way they are it makes everything when I relax everything it just comes, it comes out

Files\participant interviews\Interview by r6 with A
1 reference coded, 0.94% coverage
Reference 1: 0.94% coverage
I became able to be with people, yeah, and trust people, quite a lot, risk trusting people umm..I was at school while I was working with Catherine so I've just finished a 3-year postgraduate degree at a really, really competitive, really prestigious art school, and I graduated top of my class as well.

Files\participant interviews\Interview by r6 with r7
3 references coded, 17.23% coverage
Reference 1: 6.88% coverage
my relationship with other people is not quite easy, I am facing problem to trust in people, it’s always there, it takes quite long to trust people R6 To trust? R7 Yah. Trust people. If you find someone, even a friend or you know someone you want to be who you would like to be your friend, he want to share a life with you, it is not easy because I have a trust problem. I manage it, I have some friend as well and uh I think there are things we can share as a friend, my life sometimes I don’t have to say something about my life that’s why.
Reference 2: 6.32% coverage
the things I faced in my life, it changed me a lot but when I went to therapy, the therapy changed the way I had to think again about living with others sharing or playing with others, I used to do and now I am playing football with some friends, helps me to improve my feeling and I found some people I can trust again on them and we can share some story because all of the people we are playing football together, we had the same experience in the past … to feel the same way and help each other.
Reference 3: 4.03% coverage
if someone come for the therapy the therapist have to help people because we face problem to trust in people, they have to work on it, they have to work on it and gives us as a trauma people the trust. When someone trusts you, he can open mind and start to tell you the things he’s facing, if not, it will not be easy.

Files\participant interviews\Interview by R7 with R
2 references coded, 4.18% coverage
Reference 1: 2.44% coverage
PATIENT VIEWS ON THERAPY FOR CPTSD

I couldn't really come here to meet someone I never saw before because of..I was paranoid..and I always tell myself about my English, maybe no-one will understand yeah. And I wasn't trusting anyone anyway so ..because I wasn't feeling that safe. But now I was agreeing to do it since a few weeks ago and I didn't have that in my head, yeh.

Reference 2: 1.74% coverage

Because I'm paranoid, I still now I can't go on my own because of the trauma because I don't trust people, but I've got my people that I trust. But even with them I was like, I always found an excuse to not go out, yeh. But now I can go so it's fine.

Files\participant interviews\R1 interview with N
1 reference coded, 3.54% coverage

Reference 1: 3.54% coverage

because I didn’t trust anybody, and the therapy did help me to be more confident I can say R1: Did it help you to trust yourself more do you think? N: Yes, it did help me to trust myself more because that is which lead for by trusting myself I had time to at least to get back to trust others, not everybody but at least it did help. R1: Of course, of course at least it opened a door for you, didn’t it, is that what you are saying? N: Yes, it did bring more confidence on myself then so I can I and the help to be open a little bit too.

Files\participant interviews\R1 interview with O
2 references coded, 1.60% coverage

Reference 1: 0.45% coverage

I think I really do look at people differently and I think I have got a lot more trust and I am just very careful with who..

Reference 2: 1.15% coverage

I feel like I have come a really long way and I think without Avril I don’t think I would be feeling this way at all, so I think it is having the knowledge that someone is a professional and that you can trust their advice, because I think when you have got no trust for anyone, you need someone that makes sense.

Files\participant interviews\R2 interview with Q
5 references coded, 9.15% coverage

Reference 1: 0.94% coverage

before I don’t trust people and I feel I hate everybody. I’m so sorry but now I started to be close to people, people they show me they are all good, not all bad, but some good yes.

Reference 2: 2.11% coverage

it was on my mind, like to fear go out, like to fear everybody, not trust, I was not trust anybody in the world, I tell the truth, and I think everybody who gonna be close to me gonna kill me, was in my mind. But if I didn’t tell her I couldn’t get more improvement now because now I stay with people, people they close to me. Yeah to spoke to her I think when you spoke to someone is better I think it help,

Reference 3: 1.78% coverage

my life has changed a lot because now I have people close to me, I close to people I talk to people nicely, I started to love people, to trust people because before I was not trust anyone. I think maybe it’s the same person maybe it was in my mind I was thinking always like that, anybody who come to me gonna kill me I was always think that.

Reference 4: 1.72% coverage

therapy more I think is the more it’s like the roots, it’s the first person because therapy talk to therapy and you go to gym because you already talk to therapist you can go to gym because you already talked to if you not talk to her your cannot go to gym because you don’t trust anybody you think in the gym they gonna hurt you

Reference 5: 2.60% coverage
what I find with her I feel I spoke with someone who my best friend someone I trust and I open all what was happened to me and I open. I tell her everything about me and I no fear, no scared I was trusting her and it helped me because another person, I was not talk to another person like that I was scared this person maybe it’s this person maybe it’s with that people maybe it’s the same group with that people, but when I was spoke to her I feel I open and I feel a release, it’s called a release.

r2: I mean they say as children or toddlers growing up you need dependence to become independent and maybe that's what you need to do, you need to sort of regain that in your adulthood before ..I don't know whether things are fixed at that point where it wouldn't make much of a difference to who we are, but I don't know may yes, may no, I'm not sure. But it's quite important, the social aspect it can... CM: It is.
Aetiology of BPD and CPTSD

The term “complex post-traumatic stress disorder” was originally coined by Herman, whose ideas developed from her clinical work with abused women and girls during the early years of the feminist movement in the US in the 1970s. Her first major publication was a study of father/daughter incest (Herman, 1981/2000). The issue of diagnosis was of great concern to Herman, who described how women with such experiences had been given pejorative labels by male scientists and clinicians (1992b). She went back to Freud whose early work focused on the origins of hysteria and how to cure it. Although in “The Aetiology of Hysteria” (Freud, 1896), he postulated that “premature sexual experience” (p.203) had been present in every case of hysteria, Freud later renounced this theory and ascribed symptoms to the internal world.

Just as hysteria had negative connotations, particularly in the way it was used to undermine women’s credibility, so does the diagnosis of borderline personality disorder (BPD) in the US psychiatric manual, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In the UK the DSM-V is often used by medical professionals, as well as the ICD-11, which contains a similar diagnosis: emotionally unstable personality disorder, EUPD. It is interesting to note here that the DSM-V does not include the new CPTSD diagnosis, which has been a major disappointment for some US clinicians such as Herman and van der Kolk (2014). Herman describes borderline personality disorder as one of three disorders “which might perhaps be best understood as variants of complex post-traumatic stress disorder” (1992b, p. 126). She adds that she has documented histories of severe childhood trauma in 81% of cases of borderline personality disorder.

The stigma experienced by those with BPD is described on the website of the mental health charity, MIND, in information and advice provided for service users:

> The term ‘personality disorder’ can sound very judgemental. Being given a diagnosis or label of ‘personality disorder’ can feel as if you’re being told there’s something wrong with who you are. You may feel upset, insulted and excluded (https://www.mind.org.uk).

The overlap between CPTSD and BPD is also recognised on the same website where MIND offers the following advice under the heading, “Misdiagnosis with BPD”:

> Some of the symptoms of complex PTSD are very similar to those of borderline personality disorder (BPD) and not all professionals are aware of complex PTSD. As a result, some people are given a diagnosis of BPD or another personality disorder when complex PTSD fits their experiences more closely. It’s also possible to experience both complex PTSD and BPD at the same time (https://www.mind.org.uk).

It is useful to draw a distinction here between aetiology and symptoms because similar histories may not lead to similar symptoms. This is the approach which has been taken by two researcher groups (M. Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Frost, Hyland, Shevlin, & Murphy, 2018), who have focused on symptoms, rather than aetiology.
**Symptoms of BPD and CPTSD**

The research which has been done to distinguish BPD from CPTSD has used latent class analysis, which identifies groups of individuals who share common symptom patterns. The studies (n=280 and n=956) included women who had experienced sexual assault, mainly from the US. It is clear that CPTSD and BPD share some symptom clusters, which include affect dysregulation, negative self-concept, and disturbed relationships. However, the phenomenology of these symptom clusters may be experienced differently as summarised below in Table a.

<table>
<thead>
<tr>
<th>CPTSD</th>
<th>BPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of relationships</td>
<td>Chaotic relationships &amp; fear of abandonment</td>
</tr>
<tr>
<td>Consistently negative self-image,</td>
<td>Unstable self-image, positive &amp; negative</td>
</tr>
<tr>
<td>often shame</td>
<td></td>
</tr>
<tr>
<td>Fluctuating affect, often fear</td>
<td>Suicidal and self-harm tendencies</td>
</tr>
</tbody>
</table>

The Cloitre et al. study (2014) established four distinct groups of people, including one with PTSD, one with CPTSD, one with BPD and one with low symptoms. The Frost et al. study (2018) found that it was possible to identify CPTSD and PTSD groups, but not a separate BPD group. They concluded that the new diagnosis of CPTSD could be helpful in providing more appropriate treatment. For instance, treatment for CPTSD may focus on social engagement, self-concept and reviewing the meaning of trauma memories. By contrast, BPD treatment may be more helpful if focussed on “a reduction of self-injurious and suicidal behaviours, increasing a stable sense of self, and a reduction in dependency on others” (Frost et al., 2018, p. 6).

This is an issue which merits further research.
APPENDIX P: Transcript notations and use of names in transcripts

- Anonymity: No proper names have been used in the transcripts except those of the therapists.
- Other speakers are described by the letter allocated to the participants (letters A to S) or the initial r for researchers with numbers 1-7.
- The author is described by the initials CM.
- The transcripts included repetitions, and indeterminate noises like mm at the beginning of speech. The ‘ems’ and ‘uhs’ in the middle of sentences were not included.
- Incorrect English was transcribed as used to ensure the speaker’s words were accurately reflected.
- … Indicates a pause in speech.
- (laughs) are indicated by the word in brackets.
- If two or more people are talking at once, the second and subsequent speakers’ words are (in brackets) preceded by their letter or number.
- ‘Mmm’ indicates an indeterminate noise usually heard as mmm.
- ?? indicates inaudible or incomprehensible speech.
- There were no intonation markings.